

STATE OF INDIANA

CY 2017-2021



**INTEGRATED HIV PREVENTION AND CARE
PLAN FOR THE STATE OF INDIANA**



**Submitted by:
Division of HIV/STD/Viral Hepatitis
Indiana State Department of Health
HRSA/HAB Part B and CDC Recipient**

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GLOSSARY

COMMON ACROYNMS AND ABBREVIATIONS	
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Plan
AIDS	Acquired Immune Deficiency Syndrome
AETC	AIDS Education and Training Center
APN	Advanced Practical Nurse
ART	Antiretroviral Therapy
ASO	AIDS Service Organization
CBA	Capacity Building Assistance
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHSPAC	Comprehensive HIV Services Planning and Advisory Council
CPG	HIV Community Planning Group
CRCS	Comprehensive Rick Counseling Services
DEFA	Direct Emergency Financial Assistance
CHC	Community Health Centers
CPG	HIV Prevention Community Planning Group
CQM	Clinical Quality Management
CTR	Counseling, Testing and Referral
CTS	Counseling and Testing Sites
DHHS	Department of Health and Human Services
DIS	Disease Intervention Specialist
DMHA	Department of Mental Health and Addictions
EIHA	Early Identification of Individuals Living with HIV/AIDS
EIP	Early Intervention Plan
EIS	Early Intervention Services
eHARS	Enhanced HIV/AIDS Reporting System
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Care Center
LGBT	Lesbian, Gay, Bisexual and Transgender
HAB	HIV/AIDS Bureau
HAART	Highly Active Antiretroviral Therapy
HCV	Hepatitis C Virus
HE/RR	Health Education/Risk Reduction
HHC	Health and Hospital Corporation of Marion County
HIAP	Health Insurance Assistance Plan
HIPEP	HIV Inter-professional Education Project
HIP	Healthy Indiana Plan
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People With AIDS
HRSA	Health Resources and Services Administration

IDC	Infectious Disease Clinic
IDU	Injection Drug Use
IDOI	Indiana Department of Insurance
IDOC	Indiana Department of Correction
ISDH	Indiana State Department of Health
IU	Indiana University
LCSW	Licensed Clinical Social Worker
LSW	Licensed Social Worker
LPAP	Local Pharmacy Assistance Program
LPN	Licensed Practical Nurse
MAI	Minority AIDS Initiative
MATEC	Midwest AIDS Training and Education Center
MCM	Medical Case Management
MCPHD	Marion County Public Health Department
MDAP	Medicare Part D Assistance Plan
MSM	Men Who Have Sex with Men
NMCM	Non-medical Case Management
NHAS	National HIV AIDS Strategy
PTAC	Policy Training Advisory Council
PEP	Post-Exposure Prophylaxis
PCP	Pneumocystis carinii Pneumonia
PLWH	People Living With HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
QM	Quality Management
RISE	Ryan White Information Services Enterprise
RN	Registered Nurse
RSR	Ryan White Service Report
RWSP	Ryan White/HIV Services Program
SPSP	Special Populations Support Program
STD	Sexually-Transmitted Disease
TGA	Transitional Grant Area

DEFINITIONS	
Incidence	Incidence refers to the number or rate of new infections within a given period of time.
Prevalence	Prevalence refers to the number or proportion of all people living with an infection.
Rate	A rate is a statistically derived number used to describe the proportion of cases within a population. Unless otherwise stated, rates discussed throughout the Integrated Plan are per 100,000 residents annually.
Surveillance	Surveillance is a public health discipline that counts and reports the number of cases and the trends of a particular disease.
Unmet Need Estimate	This estimate is a calculation of the number of HIV-positive people who know their status but are not receiving HIV-related primary medical care.

EXECUTIVE SUMMARY

Indiana is a Great Lakes region state with a population of about 6.62 million people residing in 92 counties (*Appendix 1*).^{1 2} During 2015, 621 residents (9.4 per 100,000) were newly diagnosed with HIV and, at year's end, 1 of every 550 (0.18%) Indiana residents were living with HIV (N=11,698). An additional 1,718 residents are thought to be HIV-positive but undiagnosed and unaware of their status, increasing the estimated number Indiana residents living with HIV to 13,416.³ Most HIV-positive residents reside in urban counties or those with universities or correctional facilities located within their jurisdiction. Nearly three of four (72.8%) Indiana residents living with HIV reside in Marion, Lake, St. Joseph, Allen, Vanderburgh, or Clark County (*Appendix 2, Appendix 3*).

There are a wide variety of services available to Indiana residents living with, or at risk for, HIV. These include, but are not limited to: HIV counseling, testing, and prevention programs, outpatient/ambulatory primary medical care, access to medications, mental health services, substance use services, medical and non-medical case management, care coordination, access to health insurance premium and cost sharing assistance, housing, and oral health services.

Although not exhaustive, funding sources for HIV services in Indiana include: Ryan White Part A, MAI, Part B, Part C, and Part F; Centers for Disease Control and Prevention; Indiana state funds; Social Services Block Grant; Substance Abuse Prevention and Treatment Block Grant; Housing and Urban Development's Housing Opportunity for Persons with AIDS; Title X Family Planning; medication assistance programs; and, The Health Foundation of Greater Indianapolis.

Despite coordinated efforts of the various grantees, providers, and funders, challenges remain to ensure equitable access to services for all people living with HIV in Indiana. Those challenges include system, provider and client barriers, as well as societal issues such as poverty, mental health issues, and geographic isolation.

The Integrated HIV Prevention and Care Plan sets forth the goals, objectives, strategies, and suggested activities to address the HIV epidemic in Indiana from 2017 through 2021. The Plan serves as a commitment to collaboration, efficiency, and innovation among and between grantee recipients and community partners and, most importantly, responding to the needs of people living with HIV and those at risk for becoming infected with HIV in Indiana. The plan is composed of five major goals, four of which are found in and correlate with the National HIV/AIDS Strategy for the United States (NHAS). A fifth goal focusing on financial and other resources was developed and added to the plan to supplement the NHAS goals.

Implementation and monitoring of the Integrated Plan is critical for understanding which elements of the plan need to be modified or improved. This responsibility is shared by the respective Ryan White Program recipients and the Monitoring and Improvement Work Group established by the Integrated HIV Prevention and Care Plan Steering Committee in early 2016.

PURPOSE

The Purpose of the Integrated HIV Prevention and Care Plan is to provide a blueprint for HIV planning and to provide flexible direction. The Plan is intended to be a means by which to identify HIV prevention and care needs, existing resources, and barriers and gaps within the jurisdiction, as well as the goals, objectives, activities and strategies by which to address these issues. The Plan is intended to improve the efficiency of resource and program planning throughout Indiana and contribute to improvements in the various programs' effectiveness and health outcomes for Indiana residents living with, or at risk for, HIV.

The Plan is structured to:

- Address the goals and objectives as outlined in the National HIV/AIDS Strategy;
- Increase the collaboration between federal, state and local funders to increase effectiveness, efficacy, and efficient of program development and fiscal resources;
- Address all elements contained in the Curriculum of Care with the end result of increasing viral load suppression;
- Support the implementation of High-Impact Prevention programs;
- Ensure that HIV planning is efficient and focused on results-oriented processes;
- Encourage collaboration and coordination across HIV prevention, care and treatment services;
- Reduce reporting documentation;
- The Indiana State Department of Health has chosen to incorporate the state's funding cycle into the planning cycle and update the existing plan annually or as needed;
- Engage a broader group of stakeholders;
- Focus on streamlining communication, coordination and implementation of needed services across the continuum of HIV prevention, care and treatment services
- Expand services Statewide and;
- The Marion County Public Health Departments Ryan White/HIV Services Program is utilizing the Plan in conjunction with its 2015 updated Comprehensive Plan of Care to broaden its programming.

Section I: Statewide Coordinated Statement of Need

A. Epidemiologic Overview

1. Geographic Characteristics of HIV in Indiana:

Indiana is a Great Lakes region state made up of ten metropolitan statistical areas, 39 core-based statistical areas, and 92 counties (*Appendix 1*).⁴ Indiana is the 16th most populous U.S. state with an estimated population of 6,619,680, an increase of 2.1% since 2010.⁵ During 2015, 621 residents, or 9.4 [95% CI: 8.7-10.2] per 100,000, were newly diagnosed with HIV and, at year's end, 0.18% of residents were living with HIV [N=11,698; rate=176.7; 95% CI: 173.5-179.9]. An additional 1,718 residents are thought to be HIV-positive but undiagnosed and unaware of their status, increasing the estimated number of PLWH to 13,416.⁶ The greatest concentrations of PLWH are found in urban counties or those with universities or correctional facilities. Nearly three of four (72.8%) Indiana residents living with HIV reside in Marion, Lake, St. Joseph, Allen, Vanderburgh, or Clark County (N=8,521) ([Appendix 2](#), [Appendix 3](#)).

The HIV epidemic in Indiana disproportionately affects the central region of the state, which includes the Indianapolis Transitional Grant Area (TGA). The Ryan White HIV Services Program manages Part A, Part C, and Minority AIDS Initiative (MAI) funding for the Indianapolis Transitional Grant Area (TGA) and works closely with the Ryan White Part B program to ensure maximized benefits for PLWH throughout central Indiana. The Indianapolis TGA includes ten central Indiana counties: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, and Shelby, and it has an estimated population of 1,859,094. Despite accounting for only 28% of the population, the TGA is home to nearly half (48.5%) of the state's PLWH and more than a third (36.2%) of those newly diagnosed with HIV in 2015. Marion County is home to 41% of all PLWH in Indiana.

2. Socio-Demographic Characteristics of HIV in Indiana: Indiana residents are 49% male, 51% female, and predominantly non-Hispanic White (80%), non-Hispanic Black (9.3%), and Hispanic (6.7%). By age, 24% are under 18 and 15% are 65 and older. Average household size is 2.55 persons and median household income is \$48,737. Among residents 25 and older, 87.6% have at least a high school education; however, less than one-quarter (23.6%) have at least a Bachelor's degree. Of residents younger than 65, 9.6% live with a disability. Health insurance has been a complicated issue in Indiana during recent years. Implementation of the Patient Protection and Affordable Care Act (ACA) and the Healthy Indiana Plan 1115 Demonstration Project (HIP 2.0) has served to reduce the percentage of Indiana residents living without health insurance. The percent uninsured decreased from 15.3% in 2013 to 11.1% by mid-2015.⁷ Residents with income of 138%-200% of the Federal Poverty Level (FPL) (\$11,670 for a single-person household)⁸ account for most of the uninsured.⁹

When considering sex at birth, males bear the burden of HIV in Indiana, accounting for 77% of new (N=479) and 80% of existing (N=9,328) cases ([Table 1](#)). Incidence among males is 3.5 [95% CI: 2.9-4.2] times that of females, and their prevalence is 4.1 [95% CI: 3.9-4.2] times that of females. Undiagnosed HIV among males is thought to be about 2% higher than that of females.¹⁰ When considering gender identity, transgender individuals bear the greatest burden of

HIV. While accounting for less than 2% of new and existing HIV, the rate among transgendered residents is thought to be considerably higher than that of either males or females; especially among male-to-female transgendered persons (rates not calculated due to lack of population data). Research shows that prevalence of undiagnosed HIV among male-to-female transgendered individuals is at least twice that of males or females.¹¹

Table 1: HIV Prevalence and Incidence, by Gender, in Indiana: 2015								
Gender	HIV/AIDS Prevalence				HIV Incidence			
	N	%	Rate [95% CI]	Rate Ratio [95% CI]	N	%	Rate [95% CI]	Rate Ratio [95% CI]
Female	2,370	20.3	70.6 [67.8-73.5]	1.0	142	22.9	4.2 [3.6-5.0]	1.0
Male	9,328	79.7	286.0 [280.2-291.8]	4.1 [3.9-4.2]	479	77.1	14.7 [13.4-16.1]	3.5 [2.9-4.2]

By race/ethnicity, non-Hispanic Whites accounted for 58% (N=359) of new HIV diagnoses and half of all PLWH (N=5,912). Still, despite intensive outreach, Indiana’s minority residents suffer greater risk and poorer outcomes of HIV than non-Hispanic Whites across all genders and ages. While accounting for only 20% of the state’s population, minorities accounted for 42% (N=262) of new and 50% (N=5,786) of existing HIV in 2015 ([Table 2](#)). Non-Hispanic Blacks suffer the greatest burden of HIV in Indiana. While accounting for 32% (N=198) of new and 37% (N=4,306) of existing HIV, their incidence rate is 4.7 [95% CI: 4.0-5.6] times that of Whites, and their prevalence is 6.3 [95% CI: 6.0-6.5] times that of Whites. Residents of Hispanic or Other race/ethnicity have prevalence at or near twice that found among their White peers. Minorities also have a higher prevalence of undiagnosed HIV. An estimated 13.7% of non-Hispanic Blacks and 14.7% of Hispanics with HIV are thought to be undiagnosed and unaware of their status as compared to only 10.2% of non-Hispanic Whites.¹² Those most likely to have undiagnosed HIV are American Indian/Alaska Natives (18.9%), Asians (20.6%), and Native Hawaiian/Pacific Islanders (23.1%).

Table 2: HIV Prevalence and Incidence, by Race/Ethnicity, in Indiana: 2015								
Race/ Ethnicity	HIV/AIDS Prevalence				HIV Incidence			
	N	%	Rate [95% CI]	Rate Ratio [95% CI]	N	%	Rate [95% CI]	Rate Ratio [95% CI]
Black	4,306	36.8	700.3 [679.8-721.5]	6.3 [6.0-6.5]	198	31.9	32.2 [28.0-37.0]	4.7 [4.0-5.6]
Hispanic	970	8.3	219.5 [206.1-233.7]	2.0 [1.8-2.1]	45	7.2	10.2 [7.6-13.6]	1.5 [1.1-2.0]
Other	510	4.4	188.6 [173.0-205.7]	1.7 [1.5-1.8]	19	3.1	7.0 [4.5-11.0]	1.0 [0.7-1.6]
White	5,912	50.5	111.7 [108.9-114.6]	1.0	359	57.8	6.8 [6.1-7.5]	1.0

Accounting for 38.8% (N=241) of all new diagnoses, and with a rate of 26.4 per 100,000 [95% CI: 23.3-30.0], young adults 20-29 years of age experienced significantly higher HIV incidence in 2015 than any other group in Indiana ([Table 3](#)). Residents 30-39 accounted for 26% of new diagnoses and had the second highest rate at 19.3 [95% CI: 16.6-22.6]. Only 4% of new infections in Indiana occurred among residents younger than 20. Of Indiana residents living with HIV, most are 30-49 years of age (46.6%) or 50-plus (40%). Just over 1% (N=121) of PLWH in the state are under 20. There is clearly a strong inverse relationship between undiagnosed HIV and age. In fact, prevalence of undiagnosed HIV is estimated to be in the double digits until 45 years of age. Presumably, this relationship exists because as we grow older we are presented

with more opportunities to be tested or to develop symptoms of HIV infection. Nearly half (44.2%) of 13-24 year olds living with HIV are thought to be undiagnosed and unaware of their status; and prevalence of undiagnosed HIV among 25-34 year olds (26.3%) is more than twice the overall rate of 13.2%.¹³

Table 3: HIV Prevalence and Incidence, by Age, in Indiana: 2015						
Age (Yrs.)	HIV/AIDS Prevalence			HIV Incidence		
	N	%	Rate [95% CI]	N	%	Rate [95% CI]
<13	41	0.4	3.6 [2.7-4.9]	2	0.3	0.2 [0.0-0.6]
13-19	80	0.7	12.6 [10.1-15.6]	23	3.7	3.6 [2.4-5.4]
20-29	1,396	11.9	153.0 [145.2-161.2]	241	38.8	26.4 [23.3-30.0]
30-39	2,166	18.5	260.3 [249.5-271.4]	161	25.9	19.3 [16.6-22.6]
40-49	3,291	28.1	395.9 [382.6-409.6]	110	17.7	13.2 [11.0-15.9]
50+	4,724	40.4	207.0 [201.2-213.0]	84	13.5	3.7 [3.0-4.6]

The most significant HIV disparity in Indiana is among men who have sex with men (MSM). Using sound estimates,¹⁴ MSM rates were calculated based on 5.8% of the male population 15-plus years of age (N=150,468). While this represents only 2.3% of the total population, MSM accounted for 39% (N=227) of new and 51% (N=5,558) of existing HIV. When analyzing client-reported HIV exposure data, incidence and prevalence among MSM were 85 times those of people exposed via heterosexual contact ([Table 4](#)). The disparity is thought to exceed even these estimates as HIV prevalence among MSM is thought to be 18%,¹⁵ and 15% of HIV-positive MSM are thought to be undiagnosed and unaware of their status.¹⁶ Young MSM suffer far greater with 34% thought to be undiagnosed.¹⁷ Another prevalent risk in Indiana is injection drug use (IDU). Indiana was thrust into the national spotlight in 2015 when an IDU-related HIV outbreak hit rural Scott County. This resurgence of IDU-related transmission accounted for more than 30% (N=189) of new HIV cases and motivated lawmakers to implement the first syringe exchange program in the state. Based on the most recent estimate of people who inject drugs in Indiana,¹⁸ risk of HIV infection during 2015 was 113.6 [95% CI: 88.2-146.2] times that of people whose only risk factor is heterosexual contact. Furthermore, 5-6% of IDU are thought to have undiagnosed HIV.¹⁹ Among PLWH, 7.6% reported exposure via IDU. Risk of HIV via heterosexual contact accounted for 15% (N=91) of new HIV. Of people engaging in high-risk, heterosexual contact, 16.4% of men and 13.3% of women are thought to have undiagnosed HIV.²⁰ Of PLWH in Indiana, 19% reported exposure via heterosexual contact. Despite conducting thorough case investigations, an HIV exposure source was unidentified in 12% (N=74) of those newly diagnosed in 2015.

Table 4: HIV Prevalence and Incidence, by Exposure Category, in Indiana: 2015								
Exposure Category	HIV/AIDS Prevalence				HIV Incidence			
	N	%	Rate [95% CI]	Rate Ratio [95% CI]	N	%	Rate [95% CI]	Rate Ratio [95% CI]
MSM ^a	5,558	47.5	3,693.8 [3,599.7-3,790.3]	84.9 [80.8-89.1]	227	36.6	150.9 [132.5-171.8]	85.6 [67.1-109.2]
IDU ^β	435	3.7	489.3 [445.5-537.4]	11.2 [10.1-12.5]	177	28.5	200.1 [172.7-231.8]	113.6 [88.2-146.2]
MSM/IDU ^α	452	3.9	300.4 [274.0-329.3]	6.9 [6.2-7.6]	12	1.9	8.0 [4.6-13.9]	4.5 [2.5-8.3]
Heterosexual Contact ^β	2,248	19.2	43.5 [41.8-45.4]	1.0	91	14.7	1.8 [1.4-2.2]	1.0
Perinatal ^γ	140	1.2	2.1 [1.8-2.5]	0.05 [0.04-0.06]	3	0.5	3.6 [1.2-10.5]	2.0 [0.6-6.4]
Other	1,336	11.4	20.2 [19.1-21.3]	0.5 [0.43-0.50]	37	6.0	0.6 [0.4-0.8]	0.3 [0.2-0.5]
Not Identified	1,529	13.1	23.1 [22.0-24.3]	0.53 [0.50-.57]	74	11.9	1.1 [0.9-1.4]	0.6 [0.5-0.9]
^a Based on 5.8% of the male 15+ yr. old population				^β Based on most recent estimate of injection drug users in Indiana				
^γ Based on number of live births								

While implementation of the ACA and HIP 2.0 reduced the number of Indiana’s uninsured to 11.1% by mid-2015,²¹ residents living with HIV still face difficulties with access.²² Questions regarding eligibility status, confusion navigating available coverage options, enrollment/re-enrollment delays, high deductibles and co-pays, service coverage limitations, and provider availability often complicate accessing insurance for PLWH. Based on national estimates, as many as one in five (17-21%) PLWH in Indiana are uninsured and more than 40% are thought to have only public coverage (e.g., Medicaid, Medicare, HIP 2.0).^{23 24}

Poverty is a known risk factor for HIV infection, and it is also known to decrease access to and utilization of HIV-related care, especially among women.^{25 26} Several major, peer-reviewed publications provide evidence that as many as 45% of PLWH are unemployed and up to 16% are homeless due to HIV’s effect on their ability to work and maintain employment.^{27 28 29 30} To assess the prevalence of poverty among local PLWH, poverty was evaluated among all residents by zip code in the Indianapolis TGA where PLWH reside. Based on this evaluation, nearly half (46%) of the TGA’s PLWH were estimated to earn no more than FPL.^{31 32}

Many PLWH struggle with housing insecurity and the prevalence of insecurely housed/homeless PLWH throughout Indiana is unknown; however, data sources are available enabling estimation for Marion County, including:

- Housing Opportunities for Persons with AIDS reported housing 202 HIV-positive clients³³
- RWSP Part A emergency housing funds were provided for 155 clients³⁴
- eHARS and RWSP database (RISE) searches identified 61 PLWH at local homeless shelters³⁵
- A 2015 point-in-time count identified 1,666 homeless residents, 3% (N=50) of whom were HIV-positive. Based on this count, researchers estimated that 5,000-8,330 Marion County residents were homeless at some point during 2015.³⁶ Based on these findings, a projected estimate of 150-250 (3%) homeless Marion County residents were thought to be HIV-positive.

Using these data sources, the rate of homelessness among HIV-negative Marion County residents was estimated to be 504-884 per 100,000 (N=4,850-8,080). In contrast, the rate of homelessness among HIV-positive residents was estimated to be 2,756-5,855 per 100,000 (N=155-250), indicating that homelessness among Marion County residents is at least 3.2 times higher among PLWH than among HIV-negative residents [95% CI: 3.2-4.4]. Based on national research indicating that as many as 16% of PLWH could be homeless,³⁷ this disparity may be much worse than is currently known.

3. HIV Burden and Indicators of Risk in Indiana: HIV Trends

During 2011-2015, Indiana’s HIV incidence increased from 7.7 [95% CI: 7.1 8.4] to 9.4 [95% CI: 8.7-10.2] diagnoses per 100,000 residents (*Figure 1*), indicating a 20% increased risk of infection [RR=1.2; 95% CI: 1.1-1.4]. Much of this increase is attributable to the 2015 HIV outbreak in Scott County. AIDS incidence did not change significantly during this period (*Figure 2*). Prevalence of HIV (any stage) among Indiana residents in 2015 was about 13% higher than in 2011 [RR=1.13; 95% CI: 1.10-1.16], outpacing population growth six-fold (*Figure 3*). Prevalence of HIV (not AIDS) increased from 71.2 [95% CI: 69.2-73.2] to 86.5 [95% CI: 84.3-88.8], and prevalence of AIDS increased from 85.7 [95% CI: 83.5-88.0] to 90.2 [95% CI: 92.5].

Figure 1: Newly Diagnosed HIV among Indiana Residents, by Year: 2011-2015

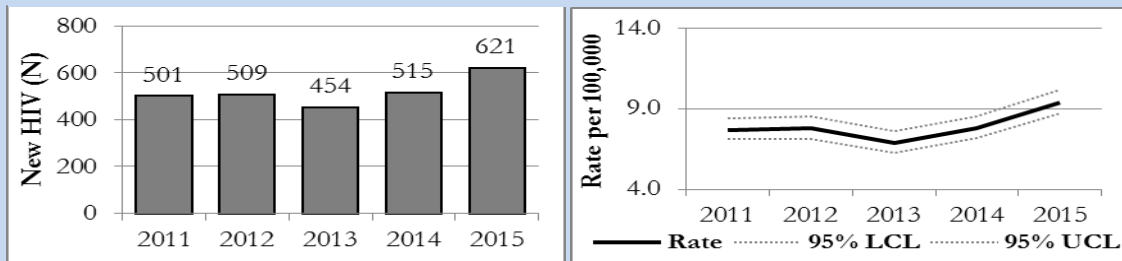


Figure 2: Newly Diagnosed AIDS among Indiana Residents, by Year: 2011-2015

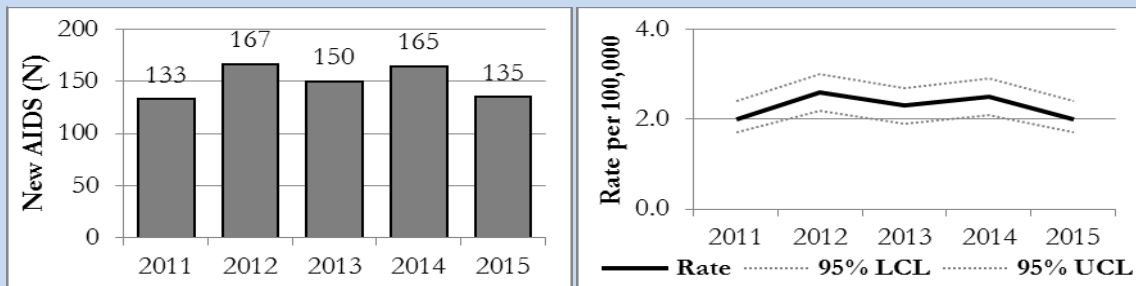
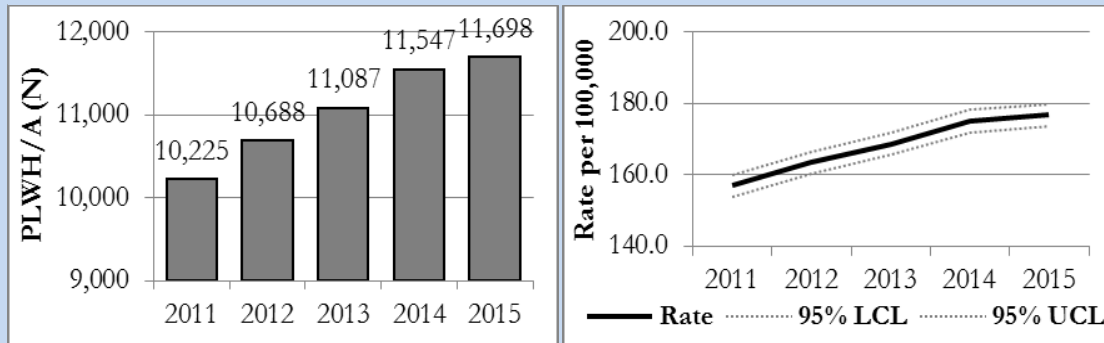


Figure 3: Indiana Residents Living with HIV/AIDS, by Year: 2011-2015



6. Geographic HIV Burden and Risk:

HIV prevalence in the Indianapolis TGA is 2.4 [95% CI: 2.3-2.5] times that of the rest of the state ([Table 5](#)). Incidence is also higher in the TGA, where residents accounted for more than a third (36.2%) of the state’s newly diagnosed HIV ([Table 6](#)).

Table 5: HIV Prevalence in the Indianapolis TGA and Select Counties vs. Indiana: 2015

Highlighted Jurisdiction			Remainder of Indiana		Rate Ratio [95% CI]
Area	N	Rate [95% CI]	N	Rate [95% CI]	
Indianapolis TGA	5,674	305.2 [297.4-313.2]	6,024	126.5 [123.4-129.8]	2.4 [2.3-2.5]
Allen County	579	157.1 [144.9-170.5]	11,119	177.9 [174.6-181.2]	NS
Clark County	294	254.8 [227.3-285.6]	11,404	175.3 [172.1-178.6]	1.5 [1.3-1.6]
Lake County	1,150	235.7 [222.5-249.7]	10,548	172.0 [168.8-175.3]	1.4 [1.3-1.5]
Marion County	4,816	512.9 [498.6-527.5]	6,882	121.1 [118.3-124.0]	4.2 [4.1-4.4]
Scott County	154	648.6 [554.2-759.0]	11,544	175.0 [171.9-178.2]	3.7 [3.2-4.3]
St. Joseph County	584	217.6 [200.6-235.9]	11,114	175.0 [171.8-178.3]	1.2 [1.1-1.4]
Vanderburgh County	322	177.0 [158.7-197.4]	11,376	176.7 [173.5-180.0]	NS
Vigo County	263	243.8 [216.0-275.0]	11,435	175.6 [172.4-178.9]	1.4 [1.2-1.6]

NS = Not Statistically Significant

Marion County, center of the Indianapolis TGA and home to the state capital, bears the greatest burden of disease by rate. Serving as home to 4,816 PLWH, prevalence is more than four times [RR=4.2; 95% CI: 4.1-4.4] that of the remainder of the state ([Table 5](#)). Marion County residents also experience a greater risk of HIV infection where incidence is about 2.6 [95% CI: 2.2-3.1] times that of other Indiana residents ([Table 6](#)). By rate, four other counties stand out. Clark, Lake, and Vigo Counties each have HIV prevalence rates roughly 1.5 times that of other Indiana residents ([Table 5](#)). There was no significant difference in incidence between these counties and the remainder of Indiana during 2015 ([Table 6](#)). Finally, there is Scott County, a stand-out among Indiana counties due to its 2015 IDU-related HIV outbreak. By rate, HIV prevalence among Scott County residents was already 3.7 [95% CI: 3.2-4.3] times that of other state

residents ([Table 5](#)). The 2015 outbreak drove HIV incidence in Scott County to a rate at least 78 [RR=94.4; 95% CI: 78.8-113.1] times that of other Indiana residents ([Table 6](#)) and will have a profound effect on prevalence in the future. Geographic location is a major factor affecting outreach, education, and testing among PLWH in the more rural and outlying areas of the state.

Table 6: HIV Incidence in the Indianapolis TGA and Select Counties vs. Indiana: 2015					
Highlighted Jurisdiction			Remainder of Indiana		Rate Ratio [95% CI]
Area	N	Rate [95% CI]	N	Rate [95% CI]	
Indianapolis TGA	225	12.1 [10.7-13.8]	396	8.3 [7.5-9.2]	1.5 [1.2-1.7]
Allen County	23	6.3 [4.2-9.4]	598	9.6 [8.8-10.4]	NS
Clark County	15	13.0 [7.9-21.5]	606	9.3 [8.6-10.1]	NS
Lake County	47	9.7 [7.3-12.8]	574	9.4 [8.6-10.2]	NS
Marion County	187	20.0 [17.3-23.1]	434	7.7 [7.0-8.4]	2.6 [2.2-3.1]
Scott County	157	665.5 [569.5-777.6]	464	7.0 [6.4-7.7]	94.4 [78.8-113.1]
St. Joseph County	19	7.1 [4.5-11.1]	602	9.5 [8.8-10.3]	NS
Vanderburgh County	11	6.1 [3.4-10.8]	610	9.5 [8.8-10.3]	NS
Vigo County	6	5.6 [2.6-12.2]	615	9.5 [8.7-10.2]	NS

5. HIV Burden and Risk by Demographic Group:

Gender:

Risk of HIV infection among male Indiana residents was 3.5 [95% CI: 2.9-4.2] times that of females in 2015, and undiagnosed HIV among males is thought to be about 2% higher than that of females.³⁸ HIV prevalence among males is also significantly higher than in their female counterparts [RR=4.1; 95% CI: 3.9-4.2]; although, men were just as likely to be linked to care within 90 days of diagnosis as their female counterparts at 78% and 80%, respectively. In addition, a slightly higher percentage of men living with HIV had suppressed viral loads in 2015, at 77% versus 74% found among women. In Central Indiana, however, outcomes among men and women were not as similar. At 97%, newly diagnosed females in the Indianapolis TGA were most likely to be linked to care within 90 days of diagnosis; whereas, only 82% of males were linked to care within this time frame. On the other hand, 25% of females were diagnosed late (received an AIDS diagnosis within 90 days of initial HIV diagnosis). Among TGA residents who received at least one viral load test in 2015, geometric mean viral load among females [71 RNA copies/mL; 95% CI: 71-85] was significantly higher than that of males [59 RNA copies/mL; 95% CI: 54-64] (P<.05). When considering gender identity, transgender individuals bear the greatest burden of HIV. While accounting for less than 2% of new and existing HIV, the rate among transgendered residents is thought to be considerably higher than that of either males or females; especially among male-to-female transgendered persons (rates not calculated due to lack of population data). Research shows that prevalence of undiagnosed HIV among male-to-female transgendered individuals is at least twice that of males or females.³⁹

Race/Ethnicity:

Non-Hispanic Blacks suffer the greatest burden of HIV in Indiana by race/ethnicity. Black residents of Indiana had a risk of HIV infection 4.7 [95% CI: 4.0-5.6] times that of Whites and

HIV prevalence 6.3 [95% CI: 6.0-6.5] times that of Whites. An estimated 13.7% of non-Hispanic Blacks are thought to be undiagnosed and unaware of their status as compared to only 10.2% of non-Hispanic Whites.⁴⁰ Among Indiana residents newly diagnosed with HIV in 2015, non-Hispanic Blacks were less likely (38.5%) than Whites (42.3%) to be diagnosed late, presumably a result of intensive outreach efforts; however, this group was also least likely to be linked to care within 90 days of diagnosis (74.2%) or to have a suppressed viral load when in care. Among Black, HIV-positive Indiana residents who received at least one viral load test during 2015 (N=2,609), 71% had a suppressed viral load (<200 RNA copies/mL), and mean viral load for this group was the highest of any racial group at 23,788 RNA copies/mL.

Age:

Young adults 20-29 years of age experienced a risk of HIV infection significantly higher than any other age group in 2015 (*Table 3*). There is a clear inverse relationship between undiagnosed HIV and age. In fact, prevalence of undiagnosed HIV is estimated to be in the double digits until 45 years of age. Presumably, this relationship exists because as we grow older we are presented with more opportunities to be tested or to develop symptoms of HIV infection. Younger age is also a consideration in the continuum of care. While age was not a likely risk factor for late linkage to care among Indiana residents overall, it was the most evident risk factor among Indianapolis TGA residents where those least likely to have been linked to care within 90 days of diagnosis were 15-19 (70%) and 20-24 (76.9%) years of age. Age is also a clear factor in viral load suppression. Indiana residents 20-29 years of age and living with HIV who received at least one viral load test during 2015 (N=790) had a lower percentage (65%) of viral load suppression when compared to older age groups. Mean viral load among Indiana's 20-29 year olds was 29,921 RNA copies/mL in 2015. Within the Indianapolis TGA, residents 20-24 years of age with at least one viral load test during 2015 (N=158) had the lowest percentage (46.2%) of viral suppression than any other age group. Nearly half (44.2%) of 13-24 year olds living with HIV are thought to be undiagnosed and unaware of their status; and prevalence of undiagnosed HIV among 25-34 year olds (26.3%) is more than twice the overall rate of 13.2%.⁴¹ HIV burden and risk are high at the opposite end of the age spectrum as well. Of Indiana residents living with HIV, most (46.6%) are 30-49 years of age (*Table 3*). Increasing resources and improved HIV treatment have led to better health outcomes and longer lives for PLWH, however, and the population of HIV-positive residents is aging. Residents 50-plus years of age (N=4,724) account for 40% of Indiana's PLWH. This is significant due to special considerations necessary in treating older PLWH such as a weakening immune system and increased risk of adverse events and drug interactions.⁴²

6. HIV Burden and Risk in Priority Populations: After careful consideration of disparities in HIV positivity rates, incidence, severity of disease at time of diagnosis, and access to and linkage to care, several populations stood out as bearing the greatest risk and burden of HIV

- Non-MSM Black men 15-44 years of age
- Black women 15-64 years of age
- MSM 15-44 years of age
- Uninsured
- Injection drug users

- Foreign born
- Recently incarcerated

Non-MSM Black Men 15-44 Years of Age:

Non-MSM Black males 15-44 years of age account for 4.6% of Indiana's population and 5.8% (N=36) of all new HIV diagnoses in 2015. Of those newly diagnosed, 20% were diagnosed late and 69% were linked to care within 90 days. When compared to HIV incidence of non-MSM White males of the same age (1 per 100,000), incidence among non-MSM Black males (11.9 per 100,000) was about twelve times higher. Of greater concern is that even as overall HIV incidence in Indiana males 15-44 years of age has been stable in recent years, incidence among Black males of this age has been steadily increasing. *Note that IDU-related infections were not included in non-MSM White incidence rate due to overrepresentation in the Southeastern Indiana Outbreak. These cases were excluded because including them would seriously skew the resulting statistics to a state that is atypical of Indiana's HIV infection rates. Non-MSM Black males who inject drugs were included because of the miniscule effect of low IDU-infection rate among non-MSM Black males in Indiana.* This disparity is just as apparent in Central Indiana where 15-44 year old non-MSM Black men account for only 3% of the Indianapolis TGA population, yet accounted for 6% (N=14) of new 2015 HIV diagnoses. HIV incidence among non-MSM Black men of this age (25.5 per 100,000) was at least three times that of non-MSM White men of the same age (3.6 per 100,000) [RR=7.0; 95% CI: 3.0-16.1]. Furthermore, while late diagnoses in this group have decreased from nearly 40% in 2013 to only 14% in 2015, linkage to care has remained steady at a very low 50%. Despite outreach efforts, this population still faces challenges such as: 1) medical illiteracy, including lack of knowledge about availability of, access to and affordability of services; 2) insufficient knowledge regarding HIV; 3) unstable housing; 4) unmet psychosocial or supportive services that impede referral to care; 5) denial about risk of HIV infection; 6) fear of discrimination/stigma; 7) internal/external homophobia; 8) failure to recognize the threat of HIV in the African American community; and, 9) mistrust of the health care system.

Black Women 15-64 Years of Age:

This priority population accounts for 5% of Indiana's population, 5% (N=31) of new 2015 HIV diagnoses, and 10% (N=1,128) of all PLWH in Indiana. When considering only 15-64 year old female residents of the state, Black women account for 22% of new and 50% of existing HIV. HIV prevalence among 15-64 year old Black women (345 per 100,000) is about four times that of Hispanic women of the same age (76.7 per 100,000) and about ten times that of their White peers (29.1 per 100,000). While linkage to care in this group is on par with Indiana at 87%, nearly one in five (19%) newly diagnosed in 2015 had converted to AIDS within 90 days. Among Indianapolis TGA females, Black women account for six of ten new and 55% of existing HIV among women in this age group. As found statewide, linkage to care in this group is on par with the Indianapolis TGA overall; however, one in four newly diagnosed in this group are diagnosed late. Major obstacles in reducing disparity among this population include: 1) lack of HIV knowledge and prevention; 2) medical illiteracy, including lack of knowledge about availability of, access to, and affordability of services; 3) unstable housing; 4) lack of resources to afford testing; 5) unmet psychosocial or supportive services that impede referral to care; 6) lack of transportation; 7) lack of affordable child care; 8) lack of communication or sexual

negotiation skills; 9) fear of stigma/discrimination; 10) denial about risk for HIV infection; 11) failure to recognize the threat of HIV in the African American community; and, 12) mistrust of the health care system.

MSM 15-44 Years of Age:

The most significant HIV disparity among Indiana's residents is MSM, especially among 15-44 year olds. Despite accounting for less than 5% of the population, MSM accounted for 47% (N=229) of 15-44 year old Indiana residents newly diagnosed with HIV in 2015 (N=487) and 50% (N=2,552) of 15-44 year old PLWH (N=5,078) statewide. Among those newly diagnosed in this priority population, 11% (N=26) were diagnosed late and 77% (N=176) were linked to care within 90 days. Among MSM, Black men bear the greatest burden of HIV. While accounting for less than 10% of the state's 15-44 year old MSM, Blacks accounted for nearly half (46%; N=106) of all MSM newly diagnosed in 2015. The disparity among 15-44 year old MSM is significantly more pronounced in Central Indiana. Using Purcell and colleagues' findings,⁴³ the population of 15-44 year old MSM was estimated to be only about 1.2% of the total Indianapolis TGA population. Despite this minuscule percentage, 15-44 year old MSM accounted for more than half (56%; N=125) of all new 2015 HIV diagnoses in the TGA and 72% of new diagnoses among 15-44 year olds. Incidence among this group far exceeds that of any other demographic group in the Indianapolis TGA at 608 new diagnoses per 100,000 [95% CI: 510-724]. Comparatively, HIV incidence among non-MSM males of the same age was only 9 per 100,000. Despite intense outreach and early intervention activities, this population has continued to suffer disproportionately statewide. Specific challenges in working with 15-44 year old MSM include: 1) lack of health and risk reduction education surrounding HIV transmission; 2) unstable housing making clients difficult to locate; 3) medical illiteracy, including lack of knowledge about availability of, access to and affordability of services; 4) substance abuse; 5) fear of discrimination; 6) internal and external stigma; 7) denial and fear of life changes associated with HIV diagnosis; 8) sex with multiple partners; 9) underestimation of personal risk; 10) internal and external homophobia; and, 11) belief that HIV is no longer a serious disease.

Uninsured:

Questions of eligibility status, confusion navigating available coverage options, enrollment/re-enrollment delays, high deductibles and co-pays, service coverage limitations, and provider availability complicate the ability of PLWH to access insurance. As many as one in five (17-21%) PLWH in Indiana are uninsured and more than 40% have only public coverage (e.g., Medicaid, Medicare, HIP 2.0). The uninsured often have no access to medical or pharmaceutical services. Access to insurance is especially important to Indiana's PLWH outside of Central Indiana because it allows clients an option to seek care beyond Ryan White Part A/C providers.

Injection Drug Users:

Indiana was thrust into the national spotlight in 2015 when an IDU-related HIV outbreak hit rural Scott County. This outbreak drove HIV incidence in Scott County to a rate at least 78 [RR=94.4; 95% CI: 78.8-113.1] times that of other Indiana residents. In comparison, IDU was reported in only 5.5% (N=13) of new HIV diagnoses in the more urban Indianapolis TGA. The resurgence of IDU-related transmission in Scott and other rural Indiana counties made up more than 30% (N=189) of newly diagnosed HIV statewide, as compared to only 1.6% prior to 2015,

motivating lawmakers to implement the first syringe exchange program in the state. Among HIV cases associated with IDU, males account for 59.8% of new and 6.5% of existing HIV in Indiana. When compared by race/ethnicity, HIV incidence among IDU is highest among non-Hispanic Whites as compared to Blacks and Hispanics. Indiana's aggressive response to the Southeastern outbreak contributed to early identification and linkage to care of those newly infected with HIV. During 2015, only 1.6% of IDU-related cases were diagnosed late, and 79% were linked to care within 90 days of diagnosis. Despite these positive outcomes, 5-6% of people living with HIV who inject drugs are thought to be undiagnosed and unaware of their status.⁴⁴ Specific challenges in working with IDU include: 1) lack of health and harm reduction education surrounding HIV transmission; 2) unstable housing making clients difficult to locate; 3) medical illiteracy, including lack of knowledge about availability of, access to and affordability of services; 4) substance abuse; 5) fear of discrimination; 6) internal and external stigma; 7) denial and fear of life changes associated with HIV diagnosis; 8) sharing of syringes and sex with multiple partners; 9) underestimation of personal risk; 10) internal and external homophobia; and, 11) belief that HIV is no longer a serious disease.

Foreign Born:

Nearly 5% of Indiana residents are thought to be foreign born and approximately half of those foreign born speak English less than 'very well'.⁴⁵ Moreover, the percentage of foreign born residents of Indiana is growing, especially among populations of Hispanic and Asian descent. The Hispanic population has more than doubled since 2000 and is thought to be underreported due to immigration and communication challenges faced by first-generation immigrants. In addition, Indiana resettles many refugees each year, particularly in Marion and Allen Counties. At least 5% (N=34) of Indiana residents newly diagnosed with HIV in 2015 were foreign born and, while there was no significant difference in incidence rate between those foreign and U.S. born [RR=0.9; 95% CI: 0.6-1.2], HIV prevalence was higher in those foreign born. In fact, HIV prevalence (N=1,132) among Indiana's foreign born residents (362.0 per 100,000) is at least double [RR=2.1; 95% CI: 2.0-2.3] that of U.S. born residents (169.6 per 100,000). Special considerations apply when working with the foreign born and, while essential for entry into and retention in care, linguistic service is not necessarily the most important of these. Foreign born residents may forego HIV testing or fail to enter HIV care out of fear, experiencing social support structures and cultural beliefs/stigma that may differ greatly from those experienced by U.S. born residents. In fact, many foreign born residents are resettled refugees who have known little but fear and instability throughout their lives, having been forced from their homes to seek asylum in a foreign country. Some, born in refugee camps, know little else. For those who do seek medical care, not all are eligible for insurance. Undocumented immigrants are ineligible for either ACA or HIP 2.0 and, although lawfully-present immigrants earning less than 400% of FPL can purchase ACA coverage, there is a five-year waiting period to qualify for Medicaid.

Recently Incarcerated:

Among Indiana residents living with HIV, at least 2.4% (N=285) have a history of incarceration. Mandatory HIV testing is performed as part of the general intake process for Indiana Department of Correction (IDOC) inmates and has revealed an HIV prevalence of 1.1%.^{46 47} IDOC released 15,679 adult inmates to Indiana during 2015.⁴⁸ Based on this information, 172 [95% CI: 148-200] formerly incarcerated PLWH are thought to have been newly released. These individuals

face many barriers including unemployment, homelessness, substance abuse, and accessing HIV care.⁴⁹ Upon release, some ex-offenders are given a 30-day supply of HIV medication but must find a provider, schedule an appointment, and pay for care prior to its depletion. Those not given medication go without until entering care. This situation illustrates poor connection between care received while incarcerated and the state's system of care. Lack of communication between systems often results in difficult transition. Ex-offenders are more likely to receive optimal care upon release if wholly involved in seeking out the care available to them. Their ability to navigate the health care system outside IDOC is dependent on the knowledge of IDOC staff.

7. HIV Burden and Risk of HIV Comorbidities:

HIV has a number of common comorbidities, a term for conditions or diseases that present together in the same person. Some can make it easier to acquire or transmit HIV, and some create a synergistic effect or complicate the disease process or treatment in PLWH. The comorbidities most common among Indiana's PLWH are discussed below.

Mental Illness & Substance Use Disorders:

Prevalence of mental illness among HIV-negative Indiana residents is estimated to be 19.1%.⁵⁰ In comparison, based on national estimates, PLWH have a prevalence as high as 50% (N=5,849).⁵¹ Substance use disorders and mental illness have similar outcomes and are often comorbid conditions. Prevalence of substance use disorders among HIV-negative Indiana residents is estimated to be 6.8%.⁵² Nationally, prevalence among PLWH is estimated to be as high as 40% (N=4,680).^{53 54} Both mental illness and substance use play important roles in treatment compliance among PLWH, as they have been shown to decrease adherence to nutrition and treatment regimens.^{55 56} In fact, when surveyed in 2013, both medical and non-medical HIV care providers ranked mental health care and substance use disorder treatment among the most important needs of PLWH.⁵⁷ Complicating matters, Marion County, home to 41% of the state's PLWH, is an underserved area for mental health services with a population-to-provider ratio only about two-thirds the average mental health staffing capacity throughout the state.⁵⁸

Sexually-Transmitted Diseases (STD):

HIV and STDs are commonly seen as co-morbid conditions. Early diagnosis and treatment can significantly reduce the rates of infertility and other complications that can occur if the infections progress. Although STDs are preventable infections, they continue to impact thousands of Indiana residents each year, complicating the approach to HIV prevention. STD-infected individuals are 2-5 times more likely to acquire HIV through sexual contact.⁵⁹ Likewise, those co-infected with an STD and HIV are more likely to transmit HIV during sexual contact. This is of particular concern in Indiana due to high rates of chlamydia, gonorrhea, and syphilis.

Chlamydia:

Chlamydia is the most commonly reported notifiable disease in the U.S. and in Indiana. During 2014, the rate of chlamydia among Indiana residents was 434 cases per 100,000 residents as compared to a national rate of 452.6.⁶⁰ Chlamydia incidence is especially high among PLWH. Despite a suspicion that chlamydia co-infection is grossly underestimated, the rate of chlamydia among HIV-positive residents during 2015 (N=186) was at least three times that of HIV-negative residents (N=28,700) [RR=3.7; 95% CI: 3.2-4.2]. The central portion of the state experienced

above average morbidity, with Marion County ranked 16th in the nation by number of reported chlamydia cases (N=9,512; rate=1,024.7).⁶¹ Similar to Indiana, the chlamydia rate among PLWH in the Indianapolis TGA was 3-4 [95% CI: 3.0-4.3] times higher among PLWH (2,385.4 per 100,000) than among HIV-negative residents (623.8 per 100,000).

Gonorrhea:

Gonorrhea is the second most commonly reported STD in the U.S., and Indiana experiences average morbidity with a rate of 111 cases per 100,000, as compared to 109.6 nationwide.⁶² Despite a suspicion that gonorrhea co-infection is grossly underreported, 2.7% of statewide gonorrhea cases during 2015 were among HIV-positive residents (N=209 of 7,843) leading to a rate about 15 times that of HIV-negative residents [RR=15.5; 95% CI: 13.5-17.7]. Gonorrhea incidence is equally high among PLWH in the Indianapolis TGA where the 2015 rate (2,846 per 100,000) was 12-17 [95% CI: 12.5-17.1] times higher than that of HIV-negative residents. As with chlamydia, gonorrhea is especially prevalent in Marion County. During 2014, Marion County ranked 11th in the nation by number of reported gonorrhea cases with a rate of 363.5 (N=3,374).⁶³

Syphilis:

Syphilis is a highly infectious and complicated infection that progresses through stages if left untreated. Syphilis is most infectious in its primary and secondary stages, but anyone with untreated syphilis of less than one year duration is considered able to transmit the infection. Syphilis is of particular concern from a public health perspective because it can cause cardiac and neurological damage (e.g., neurosyphilis) leading to blindness, deafness, memory loss, cardiac complications, and even death. Screening for syphilis among PLWH is essential because those co-infected with HIV and syphilis can experience a more rapid onset of neurosyphilis. While the 2014 statewide rate of primary/secondary syphilis (2.6 per 100,000) was lower than that of the nation as a whole (6.4 per 100,000), the number of early syphilis cases has been increasing in Indiana, particularly from 2014 (N=297) to 2015 (N=505), when Indiana experienced a 70% increase in the number of early syphilis cases reported. According to the CDC, the U.S. is seeing similar increases nationally. During 2015, 38.8% (N=196 of 505 cases) of primary, secondary, and early latent syphilis diagnoses statewide were among PLWH. The rate among PLWH (1,675.5 per 100,000) was more than 300 times that of HIV-negative Indiana residents (4.7 per 100,000) [RR=358.3; 95% CI: 299.9-428.1]. The difference in risk between HIV-positive and HIV-negative residents of the Indianapolis TGA was similar to that found statewide [95% CI of RR: 183.1-318.7].

Hepatitis C Virus (HCV):

HCV is one of the leading causes of chronic liver disease in the U.S. and it disproportionately affects PLWH.⁶⁴ Prevalence in those HIV-negative is estimated to be 1.3-1.62%.^{65 66} In comparison, an estimated 25% of PLWH are thought to be co-infected with HCV.⁶⁷ Based on this estimate, 2,925 [95% CI: 2,833-3,018] Indiana residents are thought to be HIV-HCV co-infected. Overlapping risk factors make HIV infected individuals especially vulnerable to HCV infection. For example, 50-90% of PLWH who inject drugs are co-infected with HCV.⁶⁸ When considering the HIV outbreak in Scott County, approximately 95% of the HIV-positive individuals associated with the outbreak also tested positive for HCV; whereas, 30% tested

positive for HCV only. HIV-HCV co-morbidity has serious, synergistic effects. Studies show that HCV viral loads are higher and that HCV progresses faster in those with comorbid HIV.⁶⁹ In fact, HIV co-infection triples the risk for HCV-related liver disease which is the leading cause of non-AIDS related death among PLWH.⁷⁰ HIV and HCV treatment is also complicated by drug interactions.⁷¹ Furthermore, treatment for HIV-HCV co-infection is less successful than in mono-infected individuals, making HCV an especially crucial concern for HIV care stakeholders.⁷²

B. HIV Care Continuum

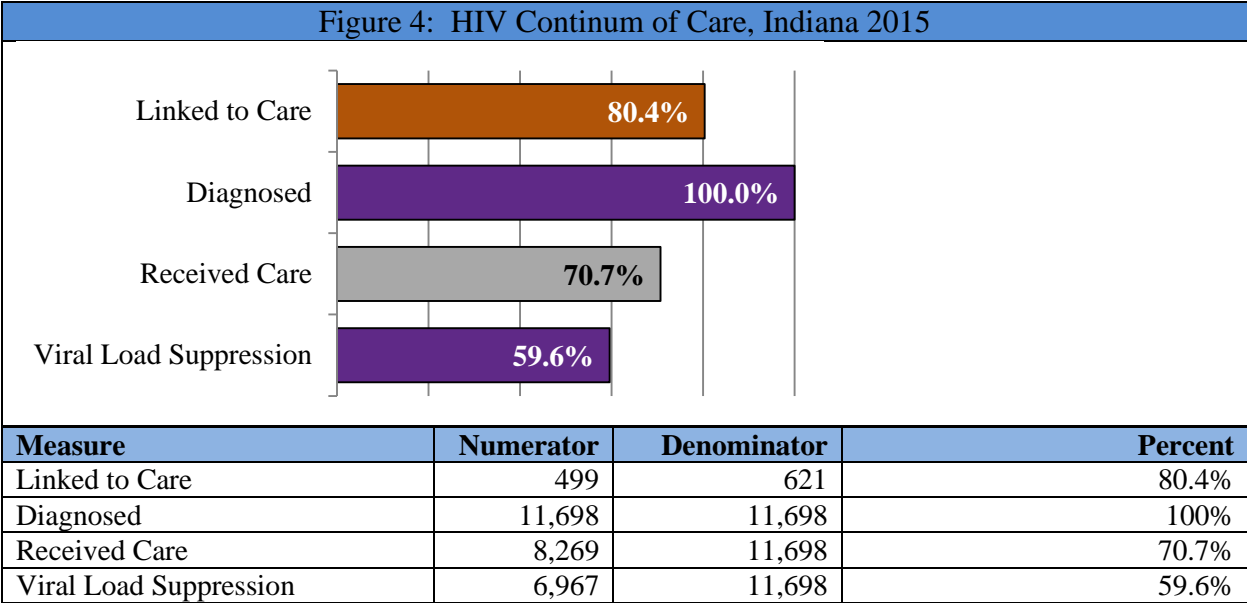
1. Definitions Used In the HIV Care Continuum: HIV outcomes are evaluated using a diagnosed-based HIV care continuum model based on: HAB measures of linkage to care, antiretroviral therapy (ART), and suppressed viral load;^{73 74} and the retention in care definition recommended by the CDC for states with complete laboratory reporting.⁷⁵ Definitions used in the HIV care continuum are provided in [Table 7](#)

Measure	Numerator	Denominator
Linked to Care	Number with first CD4/viral load test within 90 days of diagnosis	Persons newly diagnosed with HIV during 2015
HIV Prevalence	Persons living with HIV on 31DEC2015, including those undiagnosed/unaware	Persons living with HIV on 31DEC2015, including those undiagnosed/unaware
Diagnosed	Number with diagnosed HIV on 31DEC2015	Persons living with HIV on 31DEC2015, including those undiagnosed/unaware
Received Care*	Number with at least one CD4/viral load test during 2015	Number with diagnosed HIV on 31DEC2015
Retained in Care**	Number with 2+ CD4/viral load tests performed at least 3 months apart in 2015	Number with diagnosed HIV on 31DEC2015
Antiretroviral Therapy**	Number prescribed HIV antiretroviral medication during 2015	Number with diagnosed HIV on 31DEC2015
Viral Load Suppression	Number whose most recent HIV viral load test during 2015 was <200 copies/mL	Number with diagnosed HIV on 31DEC2015
* Used only in the Indiana statewide continuum of care		
** Used only in the Indianapolis TGA continuum of care		

2. Obstacles in Constructing the HIV Care Continuum:

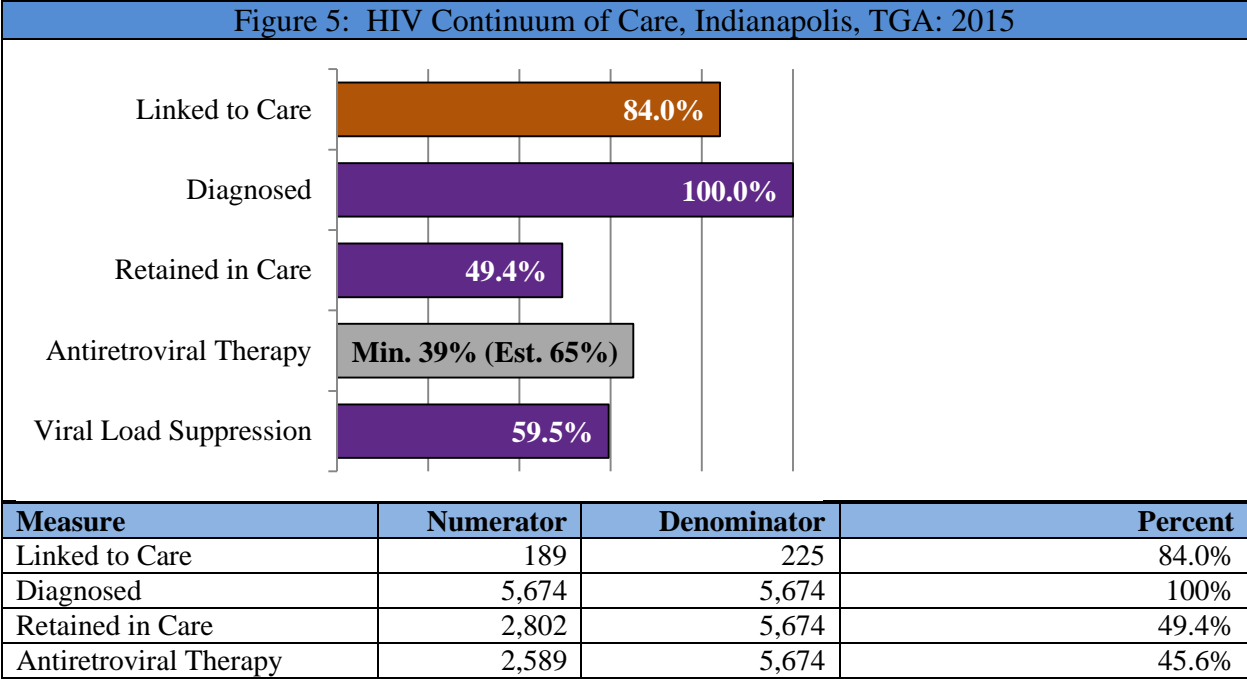
Statewide HIV Care Continuum:

The statewide HIV continuum of care ([Figure 4](#)) was revised from Integrated Plan instructions. A non-standard measure, Received Care, was substituted for the Retained in Care measure. This revision was necessary because ISDH does not yet measure retention in care. ISDH has begun working toward evaluation of retention in care for future reporting needs. In addition, while eHARS is a comprehensive surveillance database, receipt of antiretroviral therapy (ART) data is unavailable from this source. Furthermore, while dual reporting of HIV labs by ordering providers and laboratories is mandated, providers are not required to report ART prescriptions to ISDH or local health departments. Voluntary reporting requires more effort of already taxed HIV care providers leading to inconsistent reporting of ART. An analysis of Part B, Medicaid, and HIP 2.0 records could provide partial data, but only for PLWH who receive those services. For this reason, ART is missing in the statewide continuum of care.



Indianapolis TGA HIV Care Continuum:

The HIV Care Continuum for the Indianapolis TGA ([Figure 5](#)) was constructed based on Integrated Plan guidance; however, receipt of ART was estimated based on a review of the CAREWare records of Part A/C/MAI clients and viral load suppression among all others. The minimum (39%) is the number of PLWH known to have been prescribed ART during 2015 (N=2,205) while the 65% estimate is a more realistic expectation based on 60% of PLWH who were virally suppressed at their most recent 2015 viral load test.



Viral Load Suppression	3,378	5,674	59.5%
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3. Evaluation of the HIV Care Continuum in Indiana:

Linked to Care:

The 2015 statewide HIV continuum of care illustrates that 80% of people newly diagnosed with HIV were linked to care within 90 days. This finding falls just short of national linkage to care during 2013 (82%).⁷⁶ Linkage to care among residents of the Indianapolis TGA was somewhat higher (*Figure 5*) than statewide or national rates, with 84% linked to care within 90 days. Delayed linkage and poor engagement in care are associated with increased risk of secondary HIV transmission; quicker progression to AIDS; drug resistance; and, increased morbidity and mortality.^{77 78 79} It has even been argued that HIV screening without linkage to care “confers little or no benefit to the patient”.⁸⁰ Although linkage to care was 80% among Indiana residents newly diagnosed with HIV, many residents living with HIV have never been linked to, or have fallen out of, care. The updated National HIV/AIDS Strategy (NHAS) recommends that at least 85% of those newly HIV diagnosed be linked to care within 30 days.⁸¹ With these outcomes and the NHAS recommendation in mind, additional improvements in linkage to care among Indiana residents are clearly necessary. Indiana utilizes publicly-funded Counseling & Testing Sites (CTS) throughout the state that provide referrals to HIV medical care and HIV prevention services to residents identified as HIV-positive. In addition, a network of Disease Intervention Specialists (DIS) is employed to follow up on those newly identified as HIV-positive to further encourage linkage to care. In addition, Ryan White Part A Early Intervention Services (EIS) are used to identify HIV-positive residents of the Indianapolis TGA and link them to care.

HIV Prevalence & Diagnosed:

One of the challenges along the HIV care continuum is early identification and entry into care of PLWH. The CDC’s current estimate is that 12.8% of people living with HIV are thought to be undiagnosed and unaware of their status.⁸² Based on this estimate, 13,416 Indiana residents are thought to be living with HIV, but only 11,698 have been diagnosed and are aware of their status. Of these, 48.5% (N=6,507) reside in the Indianapolis TGA. The NHAS goal is that 90% of HIV-positive individuals be diagnosed and seroaware.⁸³ Indiana utilizes publicly-funded (CTS) throughout the state to provide HIV testing, counseling, and referrals to HIV medical care and prevention services. In addition, Ryan White Part A/MAI EIS, Outreach, and Health Education/Risk Reduction services are employed to identify HIV-positive residents of the Indianapolis TGA and to increase seroawareness.

Retained in Care:

Of 11,698 Indiana residents known to be living with HIV, 8,269 (70.7%) received at least one CD4 or viral load test during 2015. This finding fell between that reported nationwide during 2012 (68.1%)⁸⁴ and that reported for 2015 in the Indianapolis TGA (72%; N=4,088). While retention in care is not yet measured statewide, it is measured for Indianapolis TGA residents living with HIV. Within the TGA, 49.4% (N=2,802) of PLWH were retained in care during 2015. This finding was somewhat lower than that reported in 2012 for the U.S. (53.8%),⁸⁵ and is far below the NHAS goal of 90%,⁸⁶ yet again indicating room for improvement among Indiana residents living with HIV. Retention in care may be underreported for the TGA. Just as with

ART, medical visits are not reportable by law and are not captured in eHARS. For this reason, only HIV labs can be used to reliably calculate this outcome. Furthermore, if an individual living with HIV is privately insured or has a high deductible or co-pays, attends regular HIV primary care visits, and is ART compliant, then he or she may opt to receive only a single, annual viral load test to confirm continued viral load suppression. While current recommendations are for two viral load tests separated by at least 90 days annually, a single annual test may be chosen for cost effectiveness in the healthiest of PLWH. For this reason, some of the healthiest PLWH in the state may be considered not retained in care.

Antiretroviral Therapy:

Prescriptions for ART administered to Indiana residents living with HIV are not reportable by law; therefore, ART is not included in the statewide HIV care continuum. This measure has, however, been estimated for residents of the Indianapolis TGA based on CAREWare medical records of Ryan White Part A/C/MAI clients and viral load suppression among all others. Among TGA residents, receipt of ART during 2015 exceeded the most recent (2011) national estimate (37%)⁸⁷ by at least 2%. The 39% minimum reported includes only those known to have received prescriptions for ART based on CAREWare records (N=2,205). It is assumed that reporting of only this number would lead to a gross underestimate of those actually receiving ART. Based on the level of viral load suppression (59.6%), a more realistic estimate of ART recipients in the TGA is about 65%. Medication costs, enrollment caps, and funding restrictions can delay access to HIV medication and treatment non-compliance can lead to drug resistance and treatment failure. For these reasons, increasing access to ART is essential.

Viral Load Suppression:

The CDC reports that during 2012, 50% of U.S. residents living with HIV were virally suppressed.⁸⁸ During 2015, about 60% (59.6%; N=6,967) of PLWH in Indiana were virally suppressed. Viral load suppression among Indianapolis TGA residents was nearly identical to that of the state overall, at 59.5% (N=3,378). The NHAS goal is for at least 80% of people living with diagnosed HIV to be virally suppressed.⁸⁹

4. Disparities in the HIV Care Continuum:

Indiana residents are not equally distributed throughout the HIV care continuum. Disparities are realized among various groups and in different ways. Disparities known to affect the care continuum among Indiana residents follow.

Gender:

The percentage of men living with HIV but undiagnosed and unaware of their status is thought to be about 2% higher than that of females.⁹⁰ When considering gender identity, transgender individuals bear the greatest burden of undiagnosed HIV. Research shows that prevalence of undiagnosed HIV among male-to-female transgendered individuals is at least twice that of males or females.⁹¹ Once diagnosed, men were just as likely to be linked to care within 90 days of diagnosis as their female counterparts statewide; however, the opposite was true among residents of the Indianapolis TGA. Nearly all (97%) female residents of the TGA newly diagnosed with HIV during 2015 were linked to care within 90 days; whereas, only 82% of males were linked to care within this time frame. Women also face disparities in the continuum of care. Statewide,

men were more likely to have a suppressed viral load than their female peers. During 2015, 77% of men and 74% of women with a viral load test were virally suppressed. Female residents of the Indianapolis TGA also experience higher viral loads than their male peers. Among TGA residents with at least one 2015 viral load test, geometric mean viral load among females [71 RNA copies/mL; 95% CI: 71-85] was significantly higher than that of males [59 RNA copies/mL; 95% CI: 54-64] ($P < .05$).

Race/Ethnicity:

Racial/ethnic minorities have a higher prevalence of undiagnosed HIV than do their White peers. An estimated 13.7% of Black and 14.7% of Hispanic PLWH are thought to be undiagnosed and unaware of their status as compared to only 10.2% of Whites.⁹² Those most likely to have undiagnosed HIV are American Indian/Alaska Natives (18.9%), Asians (20.6%), and Native Hawaiian/Pacific Islanders (23.1%). Among Indiana residents newly diagnosed with HIV in 2015, Black residents were least likely to be linked to care within 90 days of diagnosis (74.2%). Among Black residents newly diagnosed, non-MSM males 15-44 years of age fared worst with only 69% linked to care within 90 days statewide, and only 50% linked to care within 90 days in the Indianapolis TGA. Non-Hispanic Black residents are also least likely to have a suppressed viral. Among Black, HIV-positive Indiana residents who received at least one viral load test in 2015 (N=2,609), only 71% had a suppressed viral load and mean viral load in this group was the highest of any racial group at 23,788 RNA copies/mL.

Age:

There is a strong inverse relationship between undiagnosed HIV and age. In fact, prevalence of undiagnosed HIV is estimated to be in the double digits until 45 years of age.⁹³ Presumably, this relationship exists because as we grow older we are presented with more opportunities to be tested or to develop symptoms of HIV infection. Nearly half (44.2%) of 13-24 year olds living with HIV are thought to be undiagnosed and unaware of their status; and prevalence of undiagnosed HIV among 25-34 year olds (26.3%) is more than twice the overall rate of 12.8%.⁹⁴ While age was not a risk factor for late linkage to care among Indiana residents overall, it was a significant risk factor among Indianapolis TGA residents where those least likely to have been linked to care within 90 days of diagnosis were 15-19 (70%) and 20-24 (76.9%) years of age. Age is also a clear factor in viral load suppression. Among the state's 20-29 year old PLWH who received at least one viral load test in 2015 (N=790), only 65% were virally suppressed and mean viral load was 29,921 RNA copies/mL. Age is the most significant factor affecting viral load suppression among residents of the Indianapolis TGA where only 46.2% of residents 20-24 years old with at least one 2015 viral load test (N=158) were virally suppressed.

Men Who Have Sex with Men (MSM):

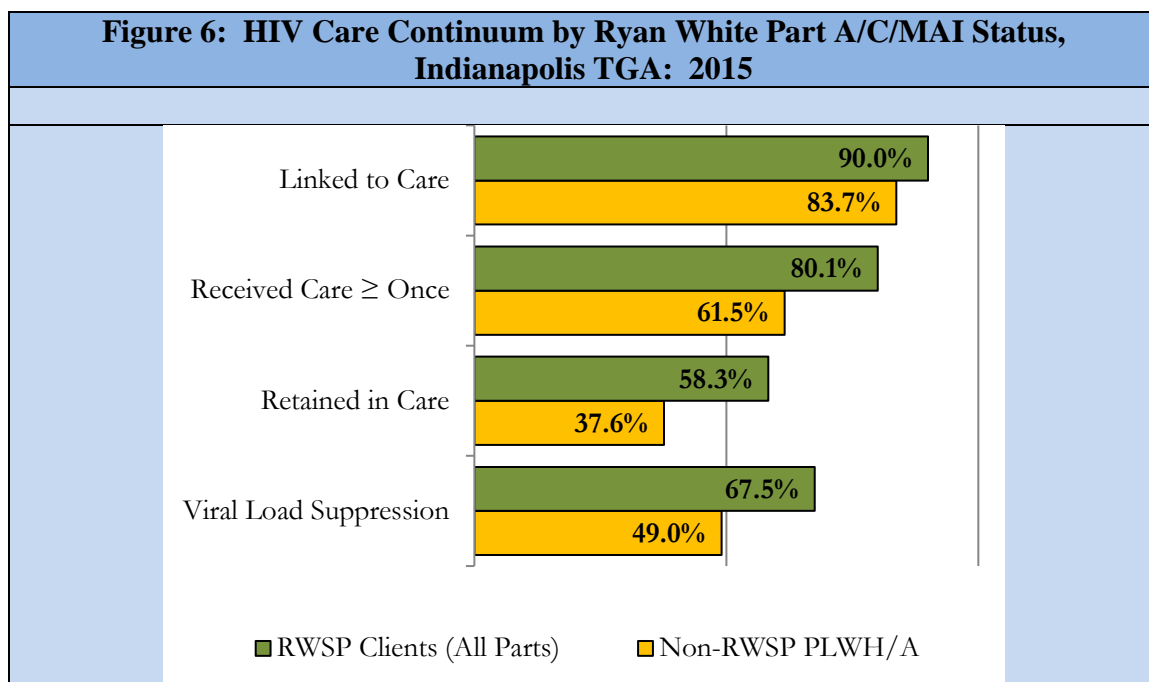
Nearly one in five MSM (18%) are thought to be HIV-positive;⁹⁵ however, 15% are thought to be undiagnosed and unaware of their status.⁹⁶ Young MSM suffer greatest with 34% thought to be undiagnosed and unaware of their status.⁹⁷ Despite targeted prevention efforts and a concentration of resources (e.g., targeted testing and prevention), linkage to care among Indiana's newly diagnosed MSM remains below the overall rate at only 77%.

Mental Illness & Substance Use Disorders:

Prevalence of mental illness and substance use disorders among PLWH in Indiana is estimated to be as high as 50% (N=5,849)⁹⁸ and 40% (N=4,680), respectively.^{99 100} Both mental health and substance use disorder co-morbidities are known to play important roles in treatment compliance among PLWH, having been shown to decrease adherence to nutrition and treatment regimens.^{101 102} Indiana's aggressive response to the Scott County outbreak contributed to early identification and linkage to care of those newly infected with HIV. During 2015, only 1.6% of IDUs were diagnosed late and 79% were linked to care within 90 days of diagnosis. Despite these positive outcomes, 5%-6% of people living with HIV who inject drugs are thought to be undiagnosed and unaware of their status.¹⁰³

Access to Ryan White Part A/C/MAI Services:

Access to both core medical and HIV supportive care are significant factors affecting retention in care and viral load suppression. Within the Indianapolis TGA, where Part A/C/MAI services are available, the HIV continuum of care was evaluated by receipt and non-receipt of these services. This care continuum ([Figure 6](#)) illustrates major differences between clients and non-clients. Nearly 20% more clients than non-clients received at least one CD4 or viral load test during 2015, and nearly 21% more clients than non-clients were retained in care throughout the year. Of those with a 2015 viral load test, 18.5% more clients than non-clients had results <200 RNA copies/mL. TGA residents were also evaluated in three groups: 1) those enrolled in services all year (<30 day enrollment lapse during the year); 2) those enrolled in services part of the year; and, 3) those not enrolled in services. Of those with a 2015 viral load test, individuals enrolled in the program part of the year (N=1,291) were more likely to have a suppressed viral load (84.4%) than those who were not enrolled (N=1,481; 81.4%), although the difference in geometric mean viral load between these groups was not statistically significant. The most obvious difference was between clients enrolled in services all year and those who were not enrolled. Of those enrolled all year (N=1,238), 87.6% had suppressed viral loads and geometric mean viral load among this group [48 RNA copies/mL; 95% CI: 42-54] was significantly lower than that of PLWH who were not enrolled [76 RNA copies/mL; 95% CI: 66-87].



C. FINANCIAL AND HUMAN RESOURCES INVENTORY

Initial discussion of the Financial and Human Resources Inventory Work Group (FHRIW) included clarification of the financial and services information required for the Integrated Plan, potential sources of this information, and possible collection strategies. Included in the discussion of potential information sources were two existing comprehensive resource/service inventories: 1) *Indiana’s Practical Guide to HIV Resources*,¹⁰⁴ and 2) *The Indianapolis Transitional Grant Area India*.¹⁰⁵ These documents were last updated in 2013 and 2012, respectively. Although once widely distributed, these documents are now in need of updating.

*Indiana’s Practical Guide to HIV Resources*¹⁰⁶ is a statewide reference tool prepared by ISDH and the Comprehensive HIV Services Planning and Advisory Council (CHSPAC). The guide is organized by Indiana’s twelve HIV Care Coordination regions and by service type within each region. Specific HIV resources and more general sources of assistance useful to persons living with HIV are included.

*The Indianapolis Transitional Grant Area 2012 Provider Resource Guide*¹⁰⁷ covers the ten-county Indianapolis TGA and was prepared by the RWSP and the Indianapolis TGA Ryan White Planning Council. This guide includes Ryan White funded core and supportive services, program eligibility and enrollment information, and non-Ryan White resources.

The FHRIW recognized that, although lacking funding detail and being generally outdated, these guides would serve as a point from which to begin information collection for the Integrated Plan, making use, for example, of the agency/service listings by region. Initial discussion included making a recommendation to update the guides in the near future.

The FHRIW decided to utilize Indiana's ten existing prevention regions, and, taking into consideration each work group member's knowledge of these regions, individuals were assigned to each region. DIS was identified in each region to serve as local resources. FHRIW members used a standard template and their own strategies for gathering information which was later combined to form regional and statewide overviews. These data were compiled into a financial and service information has been compiled into an Excel workbook, with separate worksheets organized as listed below:

- **Federal Funds Totals:** General listing of HIV-specific federal funding in Indiana broken down by service type and associated HIV Care Continuum impact. Federal funding includes: Ryan White Part A, MAI, Part B, Part C, and Part F; CDC Surveillance; Indiana State funds; Social Services Block Grant; U.S. Department of Housing and Urban Development (HUD) Housing Opportunities for People With AIDS (HOPWA); and, Title X Family Planning. ([Table8](#))
- **Ryan White Part A/MAI & C Detail (Indianapolis TGA):** Funding amounts and specific services by provider, HIV Care Continuum step impacted ([Table9](#))
- **Ryan White Part B Detail (Statewide):** Funding amounts and specific services by provider, HIV Care Continuum Step impacted ([Table10](#))
- **CDC Detail (Statewide):** Funding amounts and specific services by provider, HIV Care Continuum step impacted ([Table11](#))
- **State Funds Detail (Statewide):** Funding amounts and specific services by provider, HIV Care Continuum Step impacted ([Table12](#))
- **Prescription Assistance Sources:** Fund source, program name, assistance amount, service provider, specific service, HIV Care Continuum Step impacted (349 patients, 50% reside in Marion County) ([Table13](#))
- **The Health Foundation of Greater Indianapolis (Statewide):** Funding amounts and specific services by provider, HIV Care Continuum Step impacted, includes Direct Emergency Financial Assistance Program (DEFA) funds and MAC AIDS Fund ([Table14](#))

Table 8: Federal Funds Totals by Funder and Service FY2016, Indiana

Fund Source	Funding Amount	% of Total	Core Services	Outpatient Ambulatory/Primary Medical HIV Diagnosis/Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	AIDS Drug Assistance Program (ADAP) Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	AIDS Pharmaceutical Assistance Prescribed ART/Viral Suppression	Oral Health Care Retained in Medical Care/Viral Load Suppression	Early Intervention Services (EIS) HIV Diagnosis/Linked to Medical Care	Health Insurance Premium/Cost-Sharing Assistance Retained in Medical Care/Viral Load Suppression	Mental Health Services Retained in Medical Care	Medical Nutrition Therapy Retained in Medical Care/Viral Load Suppression	Medical Case Management Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	Substance Abuse Services-Outpatient Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	Support Services	Non-medical Case Management Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	Emergency Financial Assistance (Food and/or Utilities) Retained in Medical Care/Viral Load Suppression	Health Education/Risk Reduction Linked to Medical Care/Retained in Medical Care	Short-Term Housing Retained in Medical Care/Viral Load Suppression	Legal Services Retained in Medical Care	Linguistic Services Retained in Medical Care	Medical Transportation Services Linked to Medical Care/Retained in Medical Care Linked to Medical Care/Retained in Medical Care	Outreach Services HIV Diagnosis/Linked to Medical Care/Retained in Medical Care	Psychosocial Support Services Retained in Medical Care	HIV Testing HIV Diagnosis/Linked to Medical Care
Ryan White Part A (Indianapolis TGA)	\$4,024,248	14.85%		X		X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	
Ryan White Minority AIDS Initiative (MAI) (Indianapolis TGA)	\$266,808	0.98%		X					X	X		X					X							
Ryan White Part B (Statewide)	\$13,436,822	49.57%		X	X				X															
Ryan White Part C (Indianapolis TGA)	\$647,494	2.39%		X		X	X			X					X									

**Table 9: Ryan White Part A, MAI, & C Detail FY2016
Indianapolis, Indiana TGA**

Fund Source	Funding Amount	Funded Service Provider	Core Services	Outpatient Ambulatory/Primary Medical HIV Diagnosis/Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	AIDS Pharmaceutical Assistance Prescribed ART/Viral Suppression	Oral Health Care Retained in Medical Care/Viral Load Suppression	Early Intervention Services (EIS) HIV Diagnosis/Linked to Medical Care	Health Insurance Premium/Cost-Sharing Assistance Retained in Medical Care/Viral Load Suppression	Mental Health Services Retained in Medical Care	Medical Nutrition Therapy Retained in Medical Care/Viral Load Suppression	Medical Case Management Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	Substance Abuse Services-Outpatient Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	Support Services	Non-medical Case Management Linked to Medical Care/Retained in Medical Care/Prescribed ART/Viral Suppression	Emergency Financial Assistance Food and/or Utilities Retained in Medical Care/Viral Load Suppression	Health Education/Risk Reduction Linked to Medical Care/Retained in Medical Care	Short-Term Housing Retained in Medical Care/Viral Load Suppression	Legal Services Retained in Medical Care	Linguistic Services Retained in Medical Care	Medical Transportation Services Linked to Medical Care/Retained in Medical Care	Outreach Services HIV Diagnosis/Linked to Medical Care/Retained in Medical Care	Psychosocial Support Services Retained in Medical Care	HIV Testing HIV Diagnosis/Linked to Medical Care
Ryan White Part A	\$782,298	Damien Center					X		X		X	X		X	X		X	X			X		
	\$333,000	Damien Cares		X							X												
	\$297,044	Step-Up					X			X	X			X	X		X				X		
	\$61,765	Concord												X	X		X			X			
	\$113,388	Eskenazi Emergency Department					X														X		
	\$502,645	Eskenazi Infectious Disease Clinic		X	X						X			X									
	\$12,584	Substance Use Outreach Services					X																
	\$11,000	Horizon House					X																
	\$12,500	Community Infectious Disease		X																			
	\$82,511	Shalom					X																
	\$688,571	LifeCare-IU Health		X	X		X	X			X			X	X					X		X	
	\$100,000	ISDH						X															
	\$137,500	IU School of Dentistry				X																	
	\$50,000	Walgreens			X																		
	\$15,000	Sweet Chariot																		X			
	\$46,750	Almost4 Minds																		X			

	\$18,898	Brothers United					X										X	X	X
	\$2,717	Minority Health Coalition of Marion County					X												
	\$22,000	Rosa's Nest														X		X	X
	\$50,000	Mid America Clinical Laboratories	X																
	\$10,000	Luna Language														X			
	\$25,064	Marion County Public Health Dept Primary Medical Care Specialties	X																
Ryan White Minority AIDS Initiative (MAI)	\$71,087	Damien Center						X		X									
	\$155,700	Marion County Public Health Dept.	X					X						X					
Ryan White Part C	\$115,025	Damien Center												X					X
	\$180,000	Damien Cares	X					X		X									
	\$64,400	Step-Up												X					
	\$86,728	Eskenazi	X							X									X
	\$64,504	LifeCare-IU Health	X							X									
	\$20,000	IU School of Dentistry					X												
	\$16,000	IU School of Optometry		X															
				(Vision only)															

All providers listed above are located in Indianapolis, Indiana, Marion County.

Eligible individuals legally residing in the following 10 county area may receive services from the Ryan White HIV Services Program: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, and Shelby

The Part A grant year is March 1, 2016-February 28, 2017. The Part C grant year is January 1, 2016-December 31, 2016.

**Table 10: RYAN WHITE PART B DETAIL
INDIANA STATE DEPARTMENT OF HEALTH FY2016 INDIANA**

Funding Amount	Funded Service Provider	Funded Services	HIV Care Continuum Step
\$1,739,520	Delta Dental	Dental Insurance	Linked to Medical Care Retained in Medical Care
\$91,278	Indiana University Health Plans	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$1,145,124	All Savers/United Healthcare	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$29,043	Southeastern Indiana Health Organization (SIHO)	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$4,881,042	Anthem Insurance Cos., Inc.	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Viral Suppression
\$535,221	Coordinated Care Corporation dba Managed Health Services	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$609,615	Physicians Health Plan of Northern Indiana	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$1,277,892	Mdwise Marketplace	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$564,264	CareSource	Comprehensive Health Insurance	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$26,939,968	Unified Group Services	ADAP Administration Medications Office Visits	Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$37,812,967			

Source: Indiana State Department of Health, 2016

**Table 11: U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION FUNDS DETAIL
INDIANA STATE DEPARTMENT OF HEALTH
FY2016**

Funding Amount	Funded Service Provider	Funded Services	HIV Care Continuum Step
\$45,000	AIDS Ministries/AIDS Assist of North Indiana South Bend/Elkhart, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$95,000	AIDS Resource Group of Greater Evansville, Inc. Evansville, IN	Counseling, Testing and Referral Comprehensive Risk Counseling Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$130,000	AIDS Task Force of LaPorte/Porter Counties d.b.a. The Aliveness Project Merrillville, IN	Counseling, Testing and Referral Comprehensive Risk Counseling Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$70,000	Clark County Health Department Jeffersonville, IN	Counseling, Testing and Referral Disease Intervention Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
\$95,000	Damien Center Indianapolis, IN	Counseling, Testing and Referral Comprehensive Risk Counseling Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$90,000	Eskenazi Health Indianapolis, IN	EHTS (Expanded HIV Testing Services within a Healthcare Setting)	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$130,000	Positive Link-IU Health Bloomington/Terre Haute, IN	Counseling, Testing and Referral Comprehensive Risk Counseling Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$45,000	Northeast Indiana Positive Resource Connection Ft. Wayne, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$90,000	Step-Up, Inc. Indianapolis, IN	Community Planning Group Popular Opinion Leader	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$175,000	Brothers United Indianapolis, IN	Counseling, Testing and Referral Comprehensive Risk Counseling Services 3MV (Many Men Many Voices)	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$40,000	Imani Unidad South Bend, IN	Comprehensive Risk Counseling Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$47,100	Methodist Hospitals Gary/Merrillville, IN	EHTS (Expanded HIV Testing Services within a Healthcare Setting)	HIV Diagnosis Linked to Medical Care Retained in Medical Care

Funding Amount	Funded Service Provider	Funded Services	HIV Care Continuum Step
\$31,800	Ft. Wayne/Allen County Health Department Ft. Wayne, IN	Comprehensive Risk Counseling Services Sexually Transmitted Disease Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$300,000	Health & Hospital Corporation of Marion County Indianapolis, IN	Disease Intervention Services Sexually Transmitted Disease Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
\$80,000	Open Door Health Services Muncie, IN	Comprehensive Risk Counseling Services Disease Intervention Services Sexually Transmitted Disease Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$70,000	City of Gary Public Works Gary, IN	Disease Intervention Services Sexually Transmitted Disease Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$75,000	Monroe County Health Department Bloomington, IN	Disease Intervention Services Sexually Transmitted Disease Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$100,000	Northern Indiana Maternal and Child Health Network South Bend/Warsaw, IN	Disease Intervention Services Sexually Transmitted Disease Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$70,000	Vanderburgh County Health Department Evansville, IN	Disease Intervention Services Sexually Transmitted Disease Services	HIV Diagnosis Linked to Medical Care Retained in Medical Care
\$41,131	Health Care Education & Training Indianapolis, IN	Education	
\$32,000	Luther Consulting Carmel, IN	CDC Database Management	
TOTAL	\$1,852,031		

Funding Amount	Funded Service Provider	Funded Services	HIV Care Continuum Step
Indirectly Funded	Bartholomew County Health Department Columbus, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Boone County Health Department Lebanon, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Floyd County Health Department New Albany, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Fayette County Health Department Connersville, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Foundations Family Medicine Austin, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Hamilton County Health Department Carmel, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Hancock County Health Department Greenfield, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Henry County Health Department New Castle, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Howard County Health Department Kokomo, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	LifeCare-IU Health Indianapolis, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Matthew 25 AIDS Services Evansville, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	One Stop Shop Austin, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	PACE (Public Advocates in Community Re-Entry) Indianapolis, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Porter County Health Department Portage, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Pulaski County Health Department Winamac, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care
Indirectly Funded	Scott County Health Department Scottsburg, IN	Counseling, Testing and Referral	HIV Diagnosis Linked to Medical Care

Source: Indiana State Department of Health, 2016

**Table 12: STATE FUNDS DETAIL, FY2016
INDIANA**

Fund Source	Funding Amount	Funded Service Provider	Funded Services	HIV Care Continuum Step
State Funds Administered by Indiana State Dept. of Health	\$176,146	AIDS Ministries/AIDS Assist of North Indiana South Bend/Elkhart, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$290,000	AIDS Resource Group of Greater Evansville, Inc. Evansville, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$190,000	Aspire Indiana-Central Anderson, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$190,000	Aspire Indiana-Southeast Richmond, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$190,000	Aspire Indiana-West Lafayette, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$90,000	Aspire Indiana-Northeast Muncie, IN	Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$290,000	Clark County Health Department Jeffersonville, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$103,128	Concord Center Indianapolis, IN	Care Coordination	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$99,120	Damien Center Indianapolis, IN	Care Coordination	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression

Fund Source	Funding Amount	Funded Service Provider	Funded Services	HIV Care Continuum Step
	\$100,000	Meridian Health Services Corporation Muncie, IN	Care Coordination	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$290,000	Positive Link-IU Health Bloomington, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$95,000	Positive Link-IU Health Terre Haute, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$395,000	Northeast Indiana Positive Resource Connection Ft. Wayne, IN	Care Coordination Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$440,000	Step-Up, Inc. Indianapolis, IN	Care Coordination Community Action Group	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$180,000	Indianapolis Urban League Indianapolis, IN	Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
	\$45,000	Ft. Wayne/Allen County Health Department Ft. Wayne, IN	Special Populations Support Program	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
Total	\$3,163,394			
Total 2015 Indiana Medicaid Expenditures for HIV/AIDS	\$7,191,009			HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression
Total	\$10,354,403			

Sources: Indiana State Department of Health, 2016
Indiana Family & Social Services Administration, 2016

**Table 13: PRESCRIPTION ASSISTANCE SOURCES FY2015
INDIANA**

Fund Source	Program Name	Assistance Amount	Service Provider	Services Provided	HIV Care Continuum Step
Patient Assistance Program	Gilead Advancing Access Program	\$177,993.14	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	ViiV Healthcare Patient Assistance Program	\$47,754.80	Walgreens	Prescription Services	Prescribed ART Viral Suppression
Copay Assistance Program	Gilead Copay Coupon Card	\$231,719.57	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	ViiV Patient Savings Card	\$64,981.20	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	Isentress Multiuse Savings Coupon	\$15,440.51	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	Abbvie Patient Assistance Foundation	\$14,211.82	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	Bristol-Myers Squibb Co-Pay Assist	\$19,863.97	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	Janssen Therapeutics Patient Savings Program	\$25,702.18	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	Patient Access Network	\$57,448.92	Walgreens	Prescription Services	Prescribed ART Viral Suppression
	Other: Non-HIV medications for PLWHA	\$7,974.56	Walgreens	Prescription Services	Prescribed ART Viral Suppression
Total		\$663,090.67			
349 patients received assistance, approximately 50% reside in Marion County					

Source: Walgreens Community Pharmacy (335 Massachusetts Ave. location), Indianapolis, IN, 2016

**Table 14: PREVENTION/DEFA DETAIL FY2016
THE HEALTH FOUNDATION OF GREATER INDIANAPOLIS INDIANA, INC.**

Fund Source/Amount		Funded Service Provider	Funded Services	HIV Care Continuum Step
HIV/AIDS Prevention	DEFA*			
\$17,000	\$3,000	AIDS Ministries/AIDS Assist of North Indiana South Bend/Elkhart, IN	HIV prevention, education, and testing to MSM and IDU. Focus on African American MSM and rural communities for IDU & DEFA	HIV Diagnosis Linked to Medical Care
\$21,200	\$7,500	AIDS Resource Group of Greater Evansville, Inc. Evansville, IN	Increase HIV and HCV testing, purchase and distribute harm reduction resources, and increase high risk counseling to 11 counties served by agency & DEFA	HIV Diagnosis Linked to Medical Care
N/A	\$5,000	AIDS Task Force of LaPorte/Porter Counties d.b.a. The Aliveness Project Merrillville, IN	DEFA	Retained in Medical Care Prescribed ART Viral Suppression
N/A	\$5,000	Aspire Elwood, IN	DEFA	Retained in Medical Care Prescribed ART Viral Suppression
\$52,700	N/A	Brothers United Indianapolis, IN	Linkage to care and outreach to MSM of color and transgendered population & DEFA	Linked to Medical Care Retained to Medical Caare Viral Suppression
\$163,000	\$127,000	Damien Center Indianapolis, IN	Coordinated HIV services and linkage to care & DEFA	Linked to Medical Care Retained in Medical Care Viral Suppression
\$90,100	N/A	Eskenazi Health-Bellflower Clinic Indianapolis, IN	Expand Sex Worker Project in Marion County	HIV Diagnosis Linked to Medical Care Retained in Medical Care
N/A	\$10,000	Eskenazi Health-Infectious Disease Clinic (IDC) Indianapolis, IN	DEFA	Retained in Medical Care Prescribed ART Viral Suppression
\$63,750	\$60,000	LifeCare-IU Health Indianapolis, IN	Emergency room testing and linkage to care, case management for PrEP clinic clients & DEFA	HIV Diagnosis Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
N/A	\$10,000	Positive Link-IU Health Bloomington, IN	DEFA	Retained in Medical Care Prescribed ART Viral Suppression
\$57,000	\$7,500	Northeast Indiana Positive Resource Connection Ft. Wayne, IN	HIV counseling and testing to high risk communities, locate clients who have fallen out of care & DEFA	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression

Fund Source /Amount		Funded Service Provider	Funded Services	HIV Care Continuum Step
\$51,000	N/A	Shalom Health Care Center Indianapolis, IN	Integrated HIV testing in FQHC environment, with emphasis for African American and Hispanic patients	HIV Diagnosis Linked to Medical Care Retained in Medical Care Prescribed ART Viral Suppression
\$80,750	\$15,000	Step-Up, Inc. Indianapolis, IN	Multilayered testing/outreach program to focus on MSM & DEFA	HIV Diagnosis Linked to Medical Care Retained in Medical Care Viral Suppression Retained in Medical Care
\$15,000	N/A	Jameson Camp Indianapolis, IN	Summer camp program for development and enrichment of HIV+ youth	Retained in Medical Care Viral Suppression
\$611,500	\$250,000			

*Gregory R. Powers Direct Emergency Financial Assistance Program, administered by The Health Foundation of Greater Indianapolis. Services provided to meet emergency needs include: Nutrition, transportation, rent or mortgage assistance, insurance co-payments, and medication assistance.

Source: The Health Foundation of Greater Indianapolis, Inc., 2016

1. Workforce Capacity

In accordance with HRSA's Guidance, the AETC's findings regarding clinical workforce needs and gaps were to be provided to Part A and B programs for them to use when preparing their integrated prevention and care plans. To this end, at MATEC's 2016 Policy Training Advisory Council (PTAC) meeting, representatives from all Part A and B programs in MATEC's region were invited to discuss (among other issues) MATEC's plans to approach the assessment of the HIV workforce and to reach consensus regarding the definition of "workforce". At the PTAC meeting, the group agreed to define the HIV workforce: Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, Dental Providers and Clinical Pharmacists. For the purpose of this report, workforce is also referred to as the *clinical workforce*. However, given the nature of the data sets used to describe the findings, in some cases other HIV professionals (e.g., social workers, case managers, public health providers, etc.) were also taking into consideration.

2. HIV Workforce in Indiana

There are a wide range of professional and non-professional workers who are part of the healthcare team of people living with HIV/AIDS in Indiana. Their roles vary in the degree of patient contact and level of responsibility. This section focuses on healthcare professionals who are licensed to provide medical management of patients living with HIV in Indiana.

Dentists:

According to a 2014 Indiana Dentist Workforce Report,¹⁰⁸ dentists are the primary provider of oral health care to Indiana residents. Data from this report notes that there were 3,982 licensed dentists in Indiana in 2014. However, reaching them to complete a survey was difficult and resulted in a 13.4% response rate. The following section is based on the outcome of those surveys. The overall mean age of survey respondents was 53.0 years of age. The mean age for males (55.0) was higher than the mean age for females (48.0). No other demographic data were collected. The most common specialty reported among respondents was general dental practice (79.2%). The majority of respondents worked 25 or more hours per week (79.2%). Few respondents (4.7%) indicated working 40 or more hours per week. Less than half (40.6%) of respondents indicated that they were currently accepting new Medicaid patients. Four out of every five respondents (80.7%) listed a primary practice location in an urban county. Only 38.6 percent of respondents with practices located in urban counties reported that they were currently accepting new Medicaid patients compared to 48.8 percent of rurally located respondents. The majority of respondents (85.6%) did not report having a second practice location. Identifying dentists willing to provide care to those living with HIV/AIDS can be a challenge, especially in rural areas. In Indianapolis, the Indiana University School of Dentistry is a great resource for affordable dental care services. The Midwest AIDS Training and Education Center (MATEC) provide training to dental professionals on topics related to HIV/AIDS care.

Nurses:

Defining the nursing workforce in Indiana is complicated. Indiana's nursing workforce consists of nurses trained at various levels including Registered Nurses (RN), Licensed Practical Nurses (LPN), and Advanced Practice Nurses (APN). RNs have completed an associate or baccalaureate degree in nursing and have successfully passed national board and state licensing examinations. LPNs, which provide basic nursing care under the direction of registered nurses and physicians, generally complete a one or two year training program and receive a certificate or diploma. LPNs typically serve supportive roles within the healthcare team. APNs are registered nurses who have

completed additional training, commonly a master's degree, which gives them prescriptive authority and prepares them for advanced practice.

According to a 2013 Nursing Workforce Policy Report, a total of 99,545 RNs renewed their license to practice in Indiana 2013.¹⁰⁹ Of those surveyed, only 53,135 reported that they were practicing in Indiana and actively working in patient care. The supply of licensed RNs in Indiana has been steadily increasing, with an increase of 14,414 RNs from 1997 to 2013. Indiana's nursing workforce is primarily comprised of non-Hispanic (99%) and White (93%) professionals. In 2013, the majority (94%) of professionals working as registered nurses were female. However, the percentage of males in the nursing workforce has almost doubled over the last 16 years. The MATEC is very involved with providing training and support to this provider group due to collaboration with the Association of Nurses in AIDS Care. Most of the large HIV clinics in Indiana have one or more APNs on staff. In Indianapolis, two of the three large practices have more nurse practitioners than physicians managing HIV care.

Pharmacists:

According to a recently published 2012 Indiana pharmacist workforce report,¹¹⁰ 10,553 pharmacists renewed their license in 2012. When surveyed, only 4,790 of these pharmacists reported that they were practicing in Indiana. Of these 4,790, the majority were female (58%), White (89.9%), and non-Hispanic (98.4%). When compared to a 2004 report, there was an increase in the proportion of females in 2012, and the group is slightly more racially diverse. The mean age for all included pharmacists in 2012 was 43.4 years old. Female respondents (mean age 40.9 years old) were, on average, younger than males (mean age 46.9 years old). As treatment of HIV disease has evolved, so has the role of the pharmacist. In Indianapolis, all of the large HIV practices have one or more clinical pharmacists assisting in the management of HIV disease. Their role in HIV care is expanding due to an increase in the number of pharmacists with collaborative practice agreements with physicians.

Physicians (MD and DO):

According to a recently published 2013 Indiana Physician Workforce report,¹¹¹ there were 25,800 physicians who renewed their license to practice medicine in Indiana; however only 9,460 physicians reported providing direct patient care. In 2013, the majority of physicians were White (77.6%), male (70.8%), and not of Hispanic origin (97.5%). Of those physicians that were 65 years of age and over, the majority of them were males (89.4%). Gender distribution in the physician workforce is changing. In 2013, women accounted for approximately 48% of physicians under the age of 35; whereas, women account for only approximately 11% of physicians over the age of 65 during the same period. Physicians play a huge role in HIV care in Indiana. Even in clinics with a strong APN presence, physicians contribute to the care of patients through collaborative practice agreements with these nurse practitioners.

Physician Assistants (PA)

A data brief published in 2014 notes that the physician assistant (PA) workforce in Indiana is growing quickly.¹¹² Since 2004, the estimated number of non-government employed PAs actively working in Indiana has more than doubled, from less than 400 in 2004 to nearly 900 in 2012. The Indiana PA workforce is slightly younger than the PA workforce nationally. In 2012, approximately 80% of all US physician assistants (90% in Indiana) were under the age of 55, and the median age of PAs in clinical practice was 41 years (35 years in Indiana).

Among both US and Indiana physician assistants, 65% were female. Gender distribution reversed with age: younger Indiana PAs were predominantly female (79% of respondents under 35), while older PAs were predominantly male. Racial and ethnic diversity in the Indiana PA workforce was largely unchanged over time and remains low (93% were White).

Since 2004, the master's degree has been the most common credential among PAs in Indiana, reflecting the evolution of the profession and its educational requirements. To date, the MATEC is not aware of any PAs who provide HIV care in Indiana. PAs practicing in primary care, STD care, or emergency medicine attend HIV trainings, but they are not providing HIV care. This is likely tied to the fact that PAs were only recently granted prescriptive authority, and their practice is still evolving in Indiana.

3. Beyond Licensed Healthcare Workforce in Indiana

In addition to members of the healthcare workforce described above, there are a variety of other licensed and unlicensed professionals who are part of the healthcare team for people living with HIV/AIDS in Indiana. Patient care responsibilities vary based on education, licensure, training, and funding. This section focuses on this additional segment of the healthcare workforce.

Disease Intervention Specialists (DIS):

DIS are highly trained specialists that are able to investigate confirmed cases of reportable sexually transmitted infections (STIs), including HIV, syphilis, gonorrhea, and chlamydia. Disease Intervention Specialists, conduct voluntary interviews with patients who test positive for STIs and offer to confidentially notify, test, and preventatively treat any of their sexual and/or needle sharing contacts. Disease Intervention Specialists attempt to break the chain of disease transmission and protect the community's health by reducing the spread of infections and prophylactically treating those who could have been exposed. DIS are vital to linking Indiana residents with resources and HIV care. Indiana has approximately 30 trained DIS stationed across state.

HIV Case Managers:

As with nursing, defining the HIV Case Manager workforce in Indiana is complicated. Indiana's HIV Case Manager Workforce consists of workers trained at various levels including Licensed Clinical Social Workers (LCSW), Licensed Social Workers (LSW), and a variety of other Masters and Bachelors prepared professionals. Beyond the various levels of education and training of case managers, there are also two types of HIV case managers in Indiana. Non-medical Case Managers provide advice and assistance in obtaining medical, social, community, legal, financial, and other needed services, while Medical Case Managers provide services including coordination and follow-up of medical treatment and treatment adherence support. In 2015, the Marion County Public Health Department paid for 2,233 units of Non-medical 5,728 units of Medical HIV Case Management. A unit of service is defined as the provision of one hour of either medical or non-medical case management. These services were provided by a number of HIV Case Managers throughout the Indianapolis TGA. The Indiana State Department of Health (ISDH) funds sixty-seven HIV Care Coordination positions statewide that serve twelve regions of the state. These HIV Care Coordinators provide both medical and non-medical HIV Case Management. In Indiana, HIV Case Managers are the gateway to accessing services.

Unfortunately, caseloads are often high and pay for the positions are low, which results in high turnover.

However, some agencies have supplemented salaries and managed to retain staff for many years. These staff has become valuable resources for the state. Although specific demographic information about HIV Case Managers is not currently available, attempts are made to have them reflect the communities they serve.

HIV Prevention Specialists:

Mental Health Providers:

A 2012 report on Indiana mental health providers explained that psychiatrists are a shrinking part of the mental health workforce in Indiana, declining since 2009 to only 356 in 2013.¹¹³ There were 43 counties in which no psychiatrist reported practicing, and nearly 20% of psychiatrists indicated that they do not accept Indiana Medicaid patients, and more than 50% did not offer a sliding fee scale. This same report notes that only 76 APNs identified as practicing in psychiatric/mental health in Indiana. The number of licensed psychologists actively practicing in Indiana rose from 2010 to 2012 by about 25%, to 1,064. Between 2004 and 2012, the total number of social workers, clinical social workers, marriage and family therapists, and mental health counselors with an active license also increased, but the number of these professionals practicing in Indiana has remained roughly constant. These professionals were concentrated in urban areas, and there are five counties in which none of these professionals reported practicing. In Indiana, clinical social workers, marriage and family therapists, and mental health counselors provide much of the mental health services accessed by people living with HIV/AIDS. Many of these providers have formed partnerships with a supervising psychiatrist or an APN with a psychiatric specialty. Many of the rural HIV Care Coordination programs are co-located within community mental health centers that facilitate entry in those services.

Findings:

The findings described in this section are based on the analysis and interpretation of the existing data listed in the introduction. These data begin to inform us on current needs and gaps that may affect the overall capacity to provide HIV clinical care in Indiana. This section of the Workforce Development was completed by Midwest AIDS Training and Education Center, University of Illinois at Chicago.

Geographic Gaps of HIV Clinical Workforce Prevalence data (See [appendix 4](#))

Although HIV cases have been reported in every county in Indiana (although 8 counties have a prevalence of <5 cases), it is important to highlight the following counties with an HIV prevalence between 193 and 1150 people living with HIV (non-AIDS) in 2015: Lake, St. Joseph, Allen, Hamilton, Vigo, Monroe, Clark, and Vanderburgh counties. In Indiana (outside the Indianapolis TGA) the area of Lake County, which borders the Chicago area, is where the highest HIV prevalence rate is found. Marion County, which is home to the Indianapolis TGA, has a prevalence of 4816 people living with HIV. Scott County, which experienced an HIV outbreak among Injection drug users in 2015, saw 157 new cases of HIV during this year.

The following 10 counties ranked in the top 5% on the County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Among Persons Who Inject Drugs: Crawford,

Dearborn, Fayette, Henry, Jennings, Ripley, Scott, Starke, Switzerland and Washington. Except for Scott County, all of them currently exhibit a very low HIV prevalence.

Providers/Facilities who reported CD4 and Viral Load (VL) values in 2015

MATEC did not receive a list of Indiana providers who reported CD4 and Viral Load values in 2015. There are no findings to report in this section of the report.

Community Health Centers currently providing HIV clinical care (See [Table 15](#))

A total of 20 Community Health Centers (CHCs)—some of which also receive Ryan White funds—are currently providing HIV clinical care according to HRSA’s Data Warehouse. All 20 CHCs are in or close to counties with high reported prevalence of HIV. St. Joseph County (with a prevalence of 584 persons living with HIV), Hamilton County (218 PLWH), Vigo County (263 PLWH) and Monroe County (215 PLWH) do not have a CHC currently providing HIV clinical care services. Scott County has centers nearby in Clark County which has high HIV prevalence. None of the 20 CHCs currently providing HIV clinical care; no community health centers providing HIV clinical care is located in any of the 10 counties at high risk for rapid dissemination of HIV or HCV among persons who inject drugs. Some of these CHCs are not on MATEC’s distributions lists and may not be aware of the training and TA services available through MATEC. The following two health care centers in Indiana are the current recipients of intense assistance from MATEC under its HIV Practice Transformation Project: Shalom Health Center and Eskenazi Health Center at Grassy Creek. Both are located in Indianapolis.

Needs of the HIV Clinical Workforce Based on MATEC’s Data (See [appendix 6](#))

Except for Floyd County, all other counties with HIV prevalence above 72 persons living with HIV have been the target of MATEC’s training efforts. Among the counties with HIV prevalence between 5 and 71 persons living with HIV, MATEC’s efforts have reached providers to date in at least half of these mainly rural counties. Steuben and Spencer Counties are the only two rural counties that have not been reached by MATEC’s training efforts that are not sharing a border with a county where MATEC’s efforts have reached providers. Of the 10 counties identified as an at-risk for Hepatitis C and HIV (Scott, Crawford, Dearborn, Fayette, Henry, Jennings, Ripley, Starke, Switzerland and Washington) providers have not been reached by MATEC’s efforts in Crawford, Starke and Switzerland. Specific training and technical assistance needs in the counties mentioned above are unknown. High volume clinicians who provide HIV care (most frequently, clinicians in urban and/or Ryan White settings) have the highest level of knowledge and low-volume clinicians (frequently rural and private practice clinicians) have the lowest level of knowledge.

As low volume providers are more likely to refer HIV-positive patients for HIV care, there is an opportunity for MATEC to increase their knowledge and skill levels so that they are able to provide more advanced HIV care and retain HIV positive patients in their practices. The data from Table 15 suggest that trainings of low volume providers need to focus on initiating Anti-retroviral treatment (ART), monitoring adherence, and treating drug resistance.

Across MATEC’s region, PrEP and Treatment as Prevention was mentioned as the highest priority topic, following by Clinical Management of HIV and Testing/Routine Screening.

Additional topics that were mentioned but did not make the top of the list are: Cultural Competence with special populations (transgender clients, LGB, MSM, women), STI's, Adherence, and Primary Care/Co-Morbidities. These identified needs are addressed in the goals and objectives section of this document.

According with new HRSA guidelines for funding allocations for the AETC grantees, a significant proportion of funds have to be allocated to new projects (i.e., HIV Practice Transformation and HIV Inter-professional Education). Hence, the funding level for AETCs to fulfill other training and technical assistance needs has significantly decreased for Fiscal Years 2016 through 2019.

Results from The Black AIDS Institute HIV Work Survey ([Table 16](#)) the following was noted in reference to the workforce development. Although no fact sheet was included in the report for the state of Indiana, several of the national findings are worth mentioning here. At the national level, over 3,600 HIV workers scored an average of 61% of the questions correct. Broken down by question category, these percentages correspond to 73% correct for basic knowledge questions, 54% correct for treatment questions, and 45% correct for clinical knowledge questions. It is noted in the report that the Midwest fared better than the national average, and that HIV workers from Indiana who were included in the survey scored an average of 63% of all questions correct.

At the national level, there is an 8-11 percentage point gap between Whites and non-African Americans across all categories. This indicates the need for all states to focus its training and capacity building assistance on increasing the HIV science, treatment, and prevention knowledge among African Americans clinicians.

A number of studies have examined issues of racial concordance in clinical care and training programs. A multicenter study that examined the role of cultural distance between HIV-infected patients and providers in perceived quality of care found that patients who rated lower perceived cultural similarity with their providers rated significantly lower quality of care and lower trust in their providers. Cultural concordance was assessed in terms of speech and language, reasoning, communication style, and values, which, based on the findings of the study, indicated the importance of positive patient-provider interactions and cultural competency in provision of HIV care.¹¹⁴ Given these realities, the need for culturally competent clinicians, particularly from the communities most affected by HIV, is crucial.

Based on data from the report on familiarity with and belief in biomedical interventions, HIV workers are less familiar with the topics of Topical Microbicides and HIV vaccines; only 37% indicate that they are familiar with PrEP, and 42% are familiar with Treatment as Prevention, suggesting a need for training in these topics.

Retirement Creating Workforce Gaps

The Institute of Medicine, in examining workforce needs for HIV screening and access to care, acknowledged that the HIV/AIDS workforce is aging.¹¹⁵ They estimated nationally that 33% of physicians, 24% of pharmacists and 45% of nurses will likely reach retirement age by 2020. Meanwhile the population is increasing, and the age of the population is increasing, both of which place greater demands on health professionals.¹¹⁶ A 2008 survey of American Academy of

HIV Medicine (AAHIVM) members (N=400) found that about one-third planned to retire within 10 years.¹¹⁷ A survey of Infectious Diseases Society of America members, a physician group specializing in infectious disease care, found in 2011 that 56% of responding members (N=655 of 1,169) were 50 years of age or older; 23.7% (N=277) were 60+ years of age.¹¹⁸ In 2006, a Center for Health Workforce Studies report projected that 45% of registered nurses (RN) would reach retirement age, and that the demand for APRN-certified RNs would exceed 61,000, by the year 2020.¹¹⁹ The National Alliance for HIV Education and Workforce Development made recommendations regarding this issue:¹²⁰

“The early cohort of experienced HIV-care clinicians, who brought passion and commitment to patients early in the epidemic, entered the field 20 or more years ago and are nearing retirement. As they leave, a service gap will be created, and these providers will need to be replaced with well-educated, skilled clinicians who are able to provide comprehensive HIV care.”

MATEC efforts such as the HIV Inter-professional Education Project (HIPEP) and the Clinician Scholars Program are programmatic activities which specifically aim to prepare the next generation of skilled and dedicated HIV practitioners.

HIPEP is a regional collaborative that includes six University-based Inter Professional Education programs to develop, implement and evaluate inter-professional team-based training programs for health professions students to prepare a workforce which is ready and able to optimize care and outcomes for persons living with HIV/AIDS.

The MATEC Clinician Scholars Program is a 12-month training program specifically designed for minority or predominately minority serving, front line clinical care providers (Physicians, Physician Assistants, Nurse Practitioners, and Pharmacists), who are interested in the diagnosis, treatment, medical management, and prevention of HIV/AIDS.

Greying of Workforce – As you review the Healthcare Workforce data for Indiana you note the mean or median age of our healthcare providers. Specifically, the number of physicians aging into retirement will likely impact the Indiana workforce. It is suggested that the impact of workforce aging will be most profound in rural communities, which currently struggle with the primary care physician capacity.¹²¹ The resulting lack of availability of experienced clinicians could prove to impact patient care and prevention.

Counties Vulnerable for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs in Indiana:

The recent Scott County HIV outbreak prompted MATEC to explore the literature about rural counties in our region which may be vulnerable to similar outbreaks. In doing so, an article was found in which the authors identified U.S. counties potentially vulnerable to rapid spread of HIV, if introduced, and new or continuing high rates of HCV infection among persons who inject drugs.¹²² In Indiana, the following 9 counties, in addition to Scott, County were identified: Crawford, Dearborn, Fayette, Henry, Jennings, Ripley, Starke, Switzerland and Washington. Although, this does not mean an outbreak is imminent in these counties, it does represent a plea to the Indiana State Department of Health, the respective local health department, and MATEC to further explore vulnerability and target interventions to prevent transmission of HIV and HCV

among persons who inject drugs. These concerns are addressed in the goals and objectives section of this document.

The impact of HIV prevention and service delivery in Indiana is dependent on human resources, healthcare providers, to make health care happen. As described above, the HIV Healthcare Workforce in Indiana is made up of nurses, pharmacists, physicians, physician assistants, dentists, mental health providers, disease intervention specialist, HIV prevention specialist and HIV case managers. These people are important because the existence and quality of services to promote health, prevent illness or to cure and rehabilitate depend on the knowledge, skills and motivation of these workers. Indiana, like many other states, faces some HIV Healthcare Workforce challenges that have the potential to impact HIV prevention and service delivery.

Summary:

This report summarizes findings related to the HIV clinical workforce in Indiana. The focus includes the need for additional training and technical assistance to enhance the current and future workforce. Specific findings include: HIV cases have been reported in every county in Indiana with Marion County, the home of the Indianapolis TGA, being an outlier with 4816 cases. Efforts are under way to enhance the workforce in Scott county, which showed a high number of new HIV cases in 2015 and currently does not have a CHC that provides clinical HIV care; Crawford, Dearborn, Fayette, Henry, Jennings, Ripley, Scott, Starke, Switzerland and Washington have been identified as counties with high HIV risk; St. Joseph, Hamilton, Vigo, and Monroe counties may need attention due to lack of CHCs providing clinical HIV care. ; MATEC has provided programs to enhance the workforce in most of the counties with higher HIV prevalence, however there may be a need to focus attention on Floyd County; given shifting national priorities for the AETCs, close collaboration and resource sharing may be needed to expand programs, especially in rural areas. There may be a need to focus attention on Steuben and Spencer Counties and; Topics needing attention include PrEP, Treatment as Prevention, Clinical HIV Management and routine testing and screening.

Table 15: Community Health Centers Providing HIV Care in Indiana			
Health Center Name	City	Zip Code	HIV
Community Healthnet, Inc.	Gary	46402	0.20%
Echo Community Health Care	Evansville	47713	0.12%
Family Health Center Of Clark County, Inc.	Jeffersonville	47130	0.07%
Healthlinc, Inc.	Valparaiso	46383	0.10%
Healthnet, Inc.	Indianapolis	46203	0.13%
Heart City Health Center, Inc.	Elkhart	46517	0.05%
Indiana Health Centers, Inc.	Indianapolis	46250	0.07%
Jane Pauley Community Health Center, Inc.	Indianapolis	46229	0.11%
Madison County Community Health Center	Anderson	46016	0.02%
Neighborhood Health Clinics, Inc.	Fort Wayne	46802	0.03%
Northshore Health Centers, Inc.	Portage	46368	0.05%
Open Door Health Services, Inc.	Muncie	47305	0.02%
Purdue University	West Lafayette	47907	0.04%
Raphael Health Center	Indianapolis	46205	0.19%
Riggs Community Health Center, Inc.	Lafayette	47904	0.12%
Shalom Health Care Center, Inc.	Indianapolis	46222	0.07%
Southlake Community Mental Health Center, Inc.	Merrillville	46410	0.20%
The Health And Hospital Corporation Of Marion County	Indianapolis	46205	0.17%
Valley Professionals Community Health Center, Inc.	Clinton	47842	0.01%
Windrose Health Network, Inc.	Trafalgar	46181	0.09%

Source: Data Warehouse, Health Resources and Services Administration.

Table 16: Knowledge Scores by Question Category, Whites and African Americans 2012-13 HIV Workforce Survey					
		All Questions	Basic Knowledge and Terminology	Treatment	Biomedical Interventions
USA	All respondents	61%	73%	54%	45%
	African American (n = 68)	57%	69%	51%	41%
	White (n = 69)	67%	80%	59%	49%

Source: The Black AIDS Institute HIV Work Survey: When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce in the United States. Black AIDS Institute, 201

Integration/Interaction of Funding Sources

The successful completion of current programmatic and fiscal goals and objectives within the jurisdiction is due in large part to a concerted effort to coordinate funding streams within the jurisdiction. This collaboration includes public and private funding. It is the intent of the Plan to continue this collaboration to ensure services and funding for those services are not duplicative and are used in the most efficient and effective manner possible, while maintaining the integrity of Ryan White as the payer of last resort mandate. As a result there continues to be an expansion of programming to address the emerging needs of newly infected and underserved populations and to

help to ensure that clients who are out-of-care have increased access to points of entry into care and services. Coordination of funding from the various funding streams allows for the maintenance, implementation and expansion of a comprehensive continuum of care for PLWH within the jurisdiction, and those at risk for HIV infection. The result is increased access and utilization of counseling, testing and prevention services, medical and core services, clients entering and remaining in care which optimizes health outcomes. This combination of funding has positively impacted the goal of early HIV identification and enhanced entry into care and strengthens its compliance with the National HIV AIDS Strategy and enhancing all elements of the Continuum of Care.

The Indianapolis TGA Ryan White/HIV Services Program (RWSP) is comprised of Part A, MAI, and Part C funding. MCPHD has received Part C funding since 1991 and Part A and MAI since 2007. The Indiana State Department of Health's Division of HIV/STD/Viral Hepatitis (Part B and ADAP) has been funded since 1991. The successful achievement of programmatic and fiscal goals and objectives has been achieved by blending several funding streams, including the TGA's Ryan White Part A, Part C, and MAI and partnering with the Indiana State Department of Health's Ryan White Part B Program and State-funded Care Coordination Program. The result has been the ability to continue to expand programming that addresses the emerging needs of newly infected and underserved populations and help to ensure that clients who are out-of-care have increased access to points of entry into care and services. Combined funding from Part A, B, C, and MAI allows for the maintenance, implementation and expansion of a comprehensive continuum of care for PLWH within the Plan's jurisdiction. The result is increased identification and informing of individuals living with HIV (counseling, testing and prevention), referral to care and linkage and retention in care.

This combination of funding has positively impacted the goal of early HIV identification and enhanced entry into care. For example, the RWSP Part A program utilized Part C funds to enhance Counseling Testing and Referral programs; MAI funds for HE/RR and Outreach and Part A funds to increase funding for Early Intervention Services (EIS) and Outreach to meet the requirements of Early Identification of Individuals Living with HIV (EIIHA) and to be aligned with the National HIV AIDS Strategy and to enhance the Continuum of Care. The partnership with the EIIHA programs continues to provide care/services designed to identify clients unaware of their status, assist in individuals remaining negative, and providing access to care for clients who are not in care.

Primary activities that proved successful as a result of combined funding and collaboration remain in place for the current Plan. The first is to continue to disseminate HIV health care/resource information focusing on the importance of early diagnosis, access to and early entry into care, and retention in care. In order to reach non-English speaking persons, this information is being made available in both English and Spanish. Dissemination of information includes the use of brochures, appearances by RWSP and Planning Council members at several community events, use of Health Education and Risk Reduction (HE/RR) and outreach and peer to peer involvement. A second activity involves expanding access to rapid testing through increased funding to EIS and HIV CTR sites that have access to DIS to identify, inform, refer and link clients to care. The Federal recipients continue to partner with Disease Intervention Specialists to locate individuals testing positive for HIV and not returning for the results or those who tested HIV-positive but may not have received post-test counseling; DIS also provide partner notification services, follow-up, and referrals to care. The Part A program also continues

working with MAI Outreach and its Part A sub-recipients to locate individuals who tested positive but were not in care and to facilitate their entry into care. On an administrative level, the Part A continues to fund EIS and to utilize Part C to fund HIV Counseling and Testing Services (CTS), works with other HIV testing and referral programs, and continued to collaborate with ISDH's Division of HIV/STD/Viral Hepatitis to coordinate CTR services and CDC- funded prevention sites.

Finally, programs continue to work with health care providers to offer routine HIV CTS and increased Outreach and funding to access to testing locations frequented by members of the identified populations. The Health Foundation of Greater Indianapolis, the state's largest HIV/AIDS philanthropic granter, significantly increased funding to Eskenazi Health Services to provide HIV/Testing in their system of Federally Qualified Health Centers. This grant allowed staff of these centers (5) to receive training in counseling and testing, administering HIV testing protocols and to providing CTS. The protocol, policies and procedures for this program were developed in concert with the EIS program funded by the RWSP to the Eskenazi Emergency Department. This coordination allowed for continuity of services provisions at all levels including: identifying, informing, referring and linking to care. These activities continue to address the following goals of the NHAS: 1) Reducing new HIV infections; 2) Increasing access to care and optimize health outcomes for PLWH by increasing early disease intervention to increase the percentage of persons that enter care at a stage of HIV non-AIDS; 3) Decreasing the number of people in the TGA who are positive and unaware of their HIV status.

These jurisdictional resources – coupled with the long and successful partnerships between the Part A, B, C, and F grantees – have helped to ensure that HIV programming is comprehensive and coordinated for both prevention and care. Additional collaborations between the Ryan White recipients and CDC-funded prevention programs under the direction of the HIV Community Planning Group have also resulted in improved access for clients to points of entry into the HIV care continuum. In compliance with the National HIV/AIDS Strategy and HIV Continuum of Care Initiative, the grantees strive to implement programming that increases access to and utilization of medical and other core services; helps clients remain in care in order to optimize health outcomes; decreases disparities in access; reduces individual and community viral loads; and improves the overall quality of life for persons living with HIV. Community partnerships such as those mentioned previously help to ensure that the grantee can achieve these desired results as it continues to enhance its HIV care continuum.

Cross funding allows for the continued partnering with community agencies to meet the identified needs of the jurisdiction. The strategy to identify individuals who are unaware of their HIV status is composed of multiple components: 1) universal screening through inner city hospital EDs, a FQHC focused on meeting the needs of individuals whose first language is Spanish and agencies providing services tailored to at risk populations; 2) co-location and utilization of DIS to assist in locating and notifying individuals who are unaware of their positive status and facilitating with partner service notification; 3) utilization of outreach and HE/RR components of the RWSP; 4) collaboration with CBOs and prevention agencies providing rapid testing; 5) HIV surveillance programs; 6) agencies facilitating immediate entry into care through EIS funding; 6) agencies using peer based outreach to encourage HIV testing for those unaware and to assist in the location of those who present positive and do not return for results and to assist in linking those who are positive into care; and 7) counseling, testing and referral programs

(CTR); 8) Correctional facilities to establish a standard for pre-release HIV eligibility screening, and post-release transition to care; 9) RWSP also maintains a partnership with traditional HIV CTR sites in which core services such as partner notification, referral to care coordination, and notification of test results are offered; 10) STD Clinics to provide direct partner service notification, partner testing, and linkage to care; and 11) Non-traditional testing sites at various social service agencies.

Through subcontracts with Eskenazi Emergency Department, AIDS Services Organizations, Community Based HIV Organizations routine testing has been expanded resulting in a noticeable increase in the TGA of the number of people entering care with and HIV non-AIDS diagnosis. Through these partnerships the jurisdiction targets high risk populations such as, MSM, Hispanic, African Americans, the African American GLBT community, and persons at high risk due to mental health illness, substance abuse and homelessness. These collaborations also provide HE/RR services to individuals who test negative to aid in their remaining negative by offering or referring to HIV prevention programs.

Collaboration also continues between grantees and HIV/AIDS Surveillance to assist the early identification of people living with HIV in Indiana. Surveillance uses *eHARS* data and HIV/AIDS case reports to facilitate collaboration with DIS and the outreach programs. These cooperative efforts enable the recipients and their partners to locate, complete risk assessments, and notify individuals who test HIV positive, but did not receive post-test counseling or return for their results. All newly reported cases of HIV are referred to DIS for follow up to ensure knowledge of HIV status and to offer assistance to access care. Surveillance notifies DIS of individuals who have been lost to follow-up, and/or those who may require partner notification services. Additionally, surveillance works with the Ryan White Part A Quality Management (QM) in identifying persons who have no documentation of a CD4 count or viral load within 6-12 months of a confirmatory Western Blot, allowing for further follow-up and linkage to care. These cases are referred to the outreach staff and/or Bell Flower DIS for follow up.

Coordination between programs within the ISDH Division of HIV/STD/Viral Hepatitis has produced positive impacts on service delivery in Indiana. Coordinating one ISDH staff member to serve as the liaison for both statewide planning groups has created efficiencies in monitoring the planning groups and in escalating issues to Division leadership. ISDH has also hired a Quality Management Consultant to work on quality management and quality improvement projects across the Continuum of Care, specifically for HIV Prevention and Ryan White services. To address the needs of PLWH in rural areas, the Division has partnered with the ISDH Division of Chronic Disease, Primary Care, and Rural Health on strategies to engage providers in rural areas.

Needed Resources

Based on findings from the Human and Financial Resources narrative, there are areas in which additional resources would be helpful to the success of Indiana's Integrated Plan. The most impactful of those for prevention would be to provide funding that would increase access to prevention programs including PrEP, expansion of syringe exchange programs, increasing the number of Disease Intervention Specialists throughout the State, increasing the number of CTR sites in the rural areas of the state, educating the medical workforce on HIV Counseling, Testing and Referral, especially in rural primary care settings. There is also an identified need to increase

the number of culturally and linguistically appropriate prevention providers, including those providing HIV counseling and testing.

To address these prevention concerns the following steps are being recommended. The primary source of funding for HIV Counseling and Testing Services in Indiana comes from the ISDH through a Cooperative Agreement with the CDC. According to ISDH, CDC funding for HIV prevention programming has remained level over the last several years while the demand for Counseling, Testing, and Referral (CTR) services and other prevention programs has only increased. Exacerbating the issue is that the state of Indiana directs minimal funding for CTR services. To supplement this lack of funding, the TGA has in the past and continues to allocate funding for targeted testing through its EIS funding through Part A and HIV Counseling and Testing through Part C. However, any amount of funding that the RWSP dedicates to case-finding efforts lessens the amount of funding that can be used to provide direct services to existing cases. To aide in filling this gap one strategy is to continue current partnerships with community agencies and to work to locate additional agencies willing to provide this service. Paramount among these partnerships is the continued collaboration with the Health Foundation of Greater Indianapolis which has granted a substantial amount funds to providers to implement new or enhance existing prevention programs including those designed to link status-unaware and return status-unaware individuals to the HIV service delivery system.

Beyond the limits of available funding, other prevention challenges include the lack of coordination between various prevention and CTR programs, the lack of resources to fully integrate the prevention strategies into the system of care, the inability to blend care and prevention funding in a manner that would increase effectiveness and efficiency, and geographic challenges of providing prevention services outside of Indiana's urban centers. To address this issues their needs to be continued outreach to agencies to develop standard operating procedures and specific parameters to ensure consistency in services provision.

In the area of care, Indiana's HIV workforce would benefit from being more diverse and trained in the area of infectious disease. This is especially true in rural areas, Federal Qualified Health Care Centers, and in the offices of Primary Care Physicians. Additionally, funding to increase case management, both medical and non-medical, would improve the overall access to care for individual not living in the urban areas, are undocumented or for which English is not their first language. It is also clear that the HIV workforce in Indiana in aging and recruiting medical professionals will be vital.

To address the concerns regarding continued improvement in the workforce in Indiana the following are recommended. A part of the solution lies with the continued partnership and utilization of training provided through MATEC. The Part A, B, and C recipients should continue collaborations with the Part F grantee in an effort to increase the training opportunities targeted to mental health providers to expand the number who are willing and equipped to serve those with HIV. The Part A grantees should continue collaborations with the Part F grantee in an effort to expand the capacity of its funded mental health service providers

To address the issue or a lack of resources the in service delivery the following steps are being taken to secure them. Medical transportation continues to be problematic throughout the jurisdiction. Although current programming strives to identify agencies that can deliver the

priority services in the most efficient and effective manner possible, it remains a concern. Recognizing that capacity will never be fully sufficient to meet demand due to funding limitations, the two practical directives intended to enhance the reach and quality of services are being utilized: increasing the number of medical transportation options for consumer who live outside of the City of Indianapolis, including access to vehicular transport, gas cards or vouchers, and bus tickets.

Although there have been improvements in access to mental health services in the TGA, access remains a problems outside of that jurisdiction. One step that is being taken is to increase the number of consumers who receive mental health services by requiring all case management providers to systematically screen all enrollees for mental health concerns twice yearly. Additionally, the recipients are continuing to seek providers that will offer services in non-traditional settings and at non-traditional times. The Plan also continues to seek and establish partnerships with agencies that provide in-patient services and a means by which clients can access and receive assistance in covering the cost of that service.

Access to comprehensive health insurance is a need for clients in the jurisdiction and for which additional resources would prove beneficial. To facilitate this need and to ensure clients are familiar with insurance availability that meets their needs, there needs to be continued collaborations with service providers providing care coordination/case management to ensure that case managers are well-trained to provide health insurance navigation services that reduce the potential for provider network restrictions to negatively impact access to the most appropriate or preferred physicians.

To lessen reliance on facility-based indigent programs for primary care, the grantees are continuing to expand a network of Outpatient and Ambulatory Medical Care service providers. The Part A, B, and C grantees are establishing complementary eligibility criteria that are as generous as possible while remaining compliant with federal guidelines. The Part A and B recipients continue collaborations with service providers to ensure that consumers are able to retain any state and federal benefits for the maximum allowable duration but are also encouraged to reduce reliance on such benefits by re-entering the workforce whenever possible.

Additionally the Grantees are continuing to minimize cost-sharing requirements for primary medical care to the extent allowed by the federal guidelines. The recipients are continuing to work with its sub-recipients to increase the availability of primary medical care during hours more convenient for employed consumers (e.g., early morning, evening, or weekend hours).

To address the overall lack of affordable, accessible, adequate, and safe low-income housing in the jurisdiction, the collective recipients are continuing to support and assist the Indiana Housing and Community Development Authority in its efforts to implement the recommendations described in the Indiana HIV/AIDS Housing Plan.

To lessen reliance on time-limited housing assistance programs, the Part A, B, and C recipients will continue collaborations with service providers to ensure that case managers include budget management in the care plans for low-income clients and promote program like the Social Security Administration's *Ticket to Work* that transition consumers to employment without the loss of benefits or entitlements. The Part A, B, and C grantees will also continue collaborations

with service providers to improve access to adequate housing assistance for marginalized populations such as the mentally ill, substance users, those without citizenship status, and ex-offenders and to improve access to “appropriate” housing for the disabled and women with children.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

The following discusses the process used to develop a collaborative and coordinated needs assessment that serves to 1) identify and describe HIV prevention and care services that currently exist and those that are needed within the jurisdiction; 2) enhances the quality of services for persons at higher risk for HIV and PLWH; 3) incorporates stakeholder and community partner feedback; 4) incorporates feedback and recommendation of PLWH; 4) identifies barriers that impede access to existing services and offers guidance on the means by which to address those barriers. This section focuses on addressing the Healthy People 2020 goals and objectives and those of the National HIV/AIDS Strategy for the United States in order to develop a plan that will improve the health status of those served by this Plan. The goals that serve as the impetus for this Plan are: 1) reducing new HIV infections; 2) increasing access to care and improving health outcomes for PLWH; 3) reducing HIV related disparities and health inequities and; 4) achieving a more coordinated national response to the HIV epidemic.

The Process used to identify HIV prevention and care services needs of people at higher Risk for HIV and PLWH (diagnosed and undiagnosed).

People living with HIV and those at high risk for HIV were involved at all stages of the plan development and will be integral to its successful implementation. The three Planning Bodies, which are comprised of PLWH and/or are representative of PLWH or those at high risk for HIV were continually updated on the progress of the Plan throughout its development. To help ensure maximum involvement and input, the planning body members formalized their commitment to participation in the development and implementation of the Integrated Plan during their meetings in early in 2016. At each of the three meetings the guidance, requirements and importance of and for the Plan were explained, including the concept of utilizing working groups to focus on each section of the Plan that would need to include members from each of the Planning groups. The members of each group were asked to consider serving on one of the workgroups. Finally, each group was presented with the concept of providing a comprehensive training on the Plan that would include all three of the planning groups, and to which they were invited and strongly encouraged to attend. They were informed that the training would be conducted by HRSA consultants and would be integral to the development and implementation of the Plan.

As a part of the pre-planning process the Federal recipients (ISDH and the MCPHD) established a Steering Committee to oversee the development and implementation of the Plan. The Committee reflected equal representation for all three Planning Bodies, the two Federal recipients, PLWH and those at risk for HIV and to reflect the disease in the state of Indiana to the extent possible.

To engage the Planning Bodies in this process ISDH received technical assistance from HRSA to provide Integrated Planning pre-planning and to conduct a one day training session for the jurisdiction that included all three Planning Groups. Invitations were extended to members of the Planning Bodies, Grantee Staff and PLWH that were not a part of the Planning Bodies or Grantee Staff. The result was that 75 individuals were present at the training held on March 3, 2016.

Following the pre-training sessions with HRSA, membership in the five workgroups was solidified. Each of the workgroups included at least one member from each planning group, one staff person from ISDH and the MCPHD, one member of the Steering Committee and at least one PLWH. The first meeting of these work groups was held immediately following the HRSA training in March. At the initial meeting, each work group was given their specific duties, responsibilities, and timelines for completing their section of the Plan. At this meeting, work group members also elected a chair/co-chairs for their group and established their preference of means and frequency of meetings. All of the Chairs and/or Co-chairs were active members of the Planning Groups and included PLWH. At their initial meetings the Work Groups focused on gathering and analyzing the data in order to identify, address and implement the elements necessary for the construction and implementation of the Plan. This established the infrastructure necessary to provide the means by which to identify HIV prevention and care needs for the Indiana Integrated Plan. The Steering Committee would oversee the entire development of the Plan; the workgroups would develop the internals of the Plan; the Planning Bodies would be continually updated and concur with the Plan; and the Federal Recipients would be responsible for ensuring all parties had what they needed, provide the logistics, coordinate the groups, write the final plan, and ensure its timely implementation.

The workgroups relied on current needs assessment data (both from ISDH and MCPHD), ISDH Statewide coordinated Statement of Needs Data, the TGA's updated Comprehensive Plan, current fiscal and services utilization data, and anecdotal information from providers of services and PLWH as a primary means by which to identify jurisdictional needs. The groups relied on surveillance data, eHars data, and jurisdictional wide testing data to determine areas most impacted by new cases of HIV and assist in determining those out of care or never entering care. This also aided in the determination of needed resources for DIS. The groups were also reliant on the agencies that provide services to PLWH or those at risk for HIV to assist in identifying needs of their individual agencies or geographic areas. As many of the members of the workgroups were also providers, this information proved significant in providing data to those members that were not.

Information obtained from these processes assisted in decision making for each of the work groups with the outcome being an accumulation of a significant amount of qualitative and quantitative data. This data included both descriptive and inferential statistics on which the work groups made their decisions. All of this information was used to develop goals and objectives relevant to the PLWH in Indiana and are represented in this Plan.

In order to include community involvement the work groups and Federal recipients relied on information from a variety of community partners/sources to assess current and future care and prevention needs. Some of those partners included; 1) inner city hospital Emergency Department and their EIS program which serve a significant number of high risk individuals, especially in communities of color; 2) Hispanic FQHC focusing on identifying prevention and care needs in the Hispanic community and providing EIS; 3) agencies that provide Disease Intervention Specialists (DIS) to assist in locating and notifying individuals who are unaware of their positive status and facilitating with partner service notification and HIV testing providers and to assist in reaching those that are not in care or that have fallen out of care; 4) utilization data from providers providing outreach and Health Education and Risk Reduction Programs; 5) data from Community Based Organizations (CBOs), AIDs Service Organizations (ASO's) and prevention agencies that provide rapid testing and linkage to care; 6) HIV surveillance programs

both at the State and County level; 7) data and information from linkage to care providers; 8) agencies that use peer based outreach models to encourage HIV testing for those unaware and to assist in the location of those who present positive and do not return for results and to assist in linking those who are positive into care; 9) Early Intervention Services providers that have protocols for immediate referral or access to care for those that present positive and have a referral process for high risk negatives to assist in those individuals remaining negative; 10) counseling, testing and referral programs (CTR); 11) information regarding correctional facilities to work to establish a standard for pre-release HIV eligibility screening, and post-release transition to care; 12) traditional HIV CTR sites in which core services such as partner notification, referral to care coordination, and notification of test results are offered; 13) STD Clinics to provide direct partner service notification, partner testing, and linkage to care; and 14) non-traditional testing sites at various social service agencies; and 14) HIV Core and Supportive Service Providers.

1. HIV Prevention and Care Services Currently Available in Indiana

HIV Prevention and Care Services: Indiana State Department of Health

ISDH provides a wide range of HIV Prevention and Care services throughout the state of Indiana. Prevention and testing efforts are provided through a variety of interventions including Comprehensive Risk Counseling and Services (CRCS), Counseling Testing and Referral (CTR), Special Populations Support Program (SPSP) and the Perinatal HIV Project. While HIV Medical Services provides insurance coverage, medication assistance and Care Coordination for HIV-positive individuals living in Indiana.

ISDH HIV Prevention Services (CDC)

The goal of the Prevention Program is to increase public understanding of, involvement in, and support for HIV prevention and through those efforts, reduce the number of new infections. The focus is on eliminating racial and ethnic disparities in new infections and prevention with HIV positives. Programs are implemented statewide through designated health departments and community-based organizations (CBOs). These agencies provide education and information to initiate modification of behavior patterns or practices that put brief description of each of the prevention interventions that are provided through ISDH.

The goal of the Prevention Program is to increase public understanding of, involvement in, and support for HIV prevention and through those efforts, reduce the number of new infections. The focus is on eliminating racial and ethnic disparities in new infections and prevention with HIV positives. Programs are implemented statewide through designated health departments and community-based organizations (CBOs). These agencies provide education and information to initiate modification of behavior patterns or practices that put persons at risk of HIV infection. The Prevention Program is divided into 10 Regions.

Comprehensive Risk Planning and Services (CRCS) is a client-centered HIV prevention with the fundamental goal of promoting the adoption and maintenance of HIV risk reduction behaviors for clients with multiple and complex social behavioral problems and risk reduction needs. Risk Reduction is a hybrid of HIV risk reduction counseling and traditional case management. This approach provides intensive, ongoing, and individualized prevention counseling, support and service brokerage.

Counseling Testing and Referral (CTR) is a statewide program that coordinates the efforts of local HIV counseling and testing sites. The goal of the program is to prevent HIV transmission. It also serves to promote early detection of HIV infection and facilitate access to health care. The program ensures that partners have the opportunity to implement prevention strategies while gaining access to counseling, testing, and other services as appropriate.

Special Populations Support Program (SPSP) provides intensive support services to individuals diagnosed with HIV disease and chemical dependency. It also conducts HIV testing in treatment facilities sanctioned by the Department of Mental Health and Addictions (DMHA). The program is designed to deliver two distinct but complementary services: disease prevention and supportive care. SPSP employs certified HIV testing counselors who have been specially trained to perform comprehensive risk assessments, pre-test counseling, testing, and post-test counseling with the substance using population.

The testing counselors conduct their testing activities in a variety of venues where the target population can be found, including statewide DMHA treatment facilities. HIV positive individuals are then referred to the program's support specialists who engage the consumer with interventions designed to minimize substance use and maximize compliance with all applicable treatment plans. The support specialists works closely with local HIV Care Coordination agencies to ensure comprehensive care is provided to clients. All SPSP services are free of charge and offered throughout the state at 12 sites covering.

The Perinatal HIV Project provides consultation, education, training and technical assistance to healthcare providers, women and consumers regarding HIV counseling, and testing to pregnant women and the prevention identification and care for women with HIV and their infants.

The Capacity Building Assistance (CBA) Program within the Division of HIV/STD/Viral Hepatitis strives to assist community-based organizations and local health departments to increase and sustain their ability to deliver effective HIV prevention services throughout the state. The program's goal is to improve the performance of Indiana's HIV prevention workforce and includes the following areas: Strengthening Organizational Infrastructure, Strengthening Interventions for HIV Prevention, Strengthening Community Access to and Utilization of HIV Prevention Services, and Strengthening Community Planning for HIV Prevention. Once a need for CBA is identified, the assistance will be provided or organized by the CBA Program staff.

The Indiana HIV Prevention Community Planning Group (CPG) is a Center for Disease Control and Prevention mandated advisory board that is comprised of persons throughout the state of Indiana who are either infected or affected by HIV/AIDS. The mission of the CPG is to collaborate with the Indiana State Department of Health (ISDH) as well as other key stakeholders to support the development, implementation and monitoring of engagement strategies for HIV prevention planning that will increase access to HIV prevention, care, and treatment services in the state of Indiana.

ISDH HIV Medical Services:

The Medical Services Program provides assistance to individuals with HIV disease in need of therapeutic medications and medical services. It is designed to give an individual full access to comprehensive health insurance at no cost to the person enrolled in the program. The program provides both short-term and long-term benefit packages covering basic healthcare services, as well as a range of HIV-related medical services and FDA approved ART medications. Four different plans are offered including the Health Insurance Plan (HIAP), AIDS Drug Assistance Plan (ADAP), Early Intervention Plan (EIP) and Medicare Part D assistance Plan (MDAP) Insurance packages are offered on a tiered system that allows clients to move between insurance programs depending on their needs. The table ([Table 17](#)) summarizes each plan’s insurance coverage and eligibility requirements.

Table 17: Comprehensive Health Insurance Options		
Type of Plan	Type of Coverage	Eligibility Requirements
HIAP	<ul style="list-style-type: none"> • Purchase insurance plans through private carriers via the Indiana Health Insurance Marketplace • Pays premiums, deductible, co-pay & insurance 	Must be an Indiana resident, HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of FPL, be uninsured and under 65 years old
ADAP	<ul style="list-style-type: none"> • Assists individuals in obtaining limited FDA-approved ART medication, until HIAP coverage is effective. • Once HIAP coverage is obtained, ADAP benefits expire. • A drug formulary is used to determine which ART medications are covered under the plan. Formulary is updated as new FDA-approved ART medication becomes available. 	Must be an Indiana resident, HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of FPL & be uninsured.
EIP	<ul style="list-style-type: none"> • Provides immediate access to HIV medical services until HIAP coverage begins. • EIP benefits expire once HIAP coverage is effective. • Covers costs associated with medical services such as doctor visits, lab services, vaccinations. 	Must be an Indiana resident, HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of FPL, be uninsured & under 65 years old.
Medicare Part D Assistance Plan (MDAP)	Provides assistance towards co-pays, coinsurance, and deductible costs associated with Medicare prescription drug plans.	Must be an Indiana resident, HIV-positive, enrolled in HIV Care Coordination, earn less than 300% of FPL, be enrolled in Medicare Parts A and B as well as a Medicare prescription drug plan

HIV Care Coordination

In addition to the Medical Services program, ISDH also has an HIV Care Coordination program. Care Coordination is a specialized form of HIV case management with a mission is to assist those living with HIV disease and offer coordination among a wide variety of health and social services. Case Management services are available statewide at sixteen regional sites. Care Coordination provides an individualized plan of care that includes medical, psychosocial, financial, and other supportive services, as needed. Care Coordination services are offered free of charge. The primary goals of the program are to ensure the continuity of care, to promote self-sufficiency, and to enhance the quality of life for individuals living with HIV. The Care Coordinators are trained professionals who can offer assistance in the following areas: access to emergency funds, send referrals for a variety of services including mental health, substance abuse programs, dental appointments or other support services. Care coordinators can also assist with transportation and medication management.

Comprehensive HIV Services Planning and Advisory Council (CHSPAC): The overall mission of the Council is to work in partnership with Indiana State Department of Health (ISDH). Jointly, the Council and ISDH share the mission of assuring HIV-positive individuals and their families access to a comprehensive network of high quality care and treatment services. The Indiana State Department of Health's Division of HIV/STD/Viral Hepatitis formed the Indiana Comprehensive HIV Services Planning and Advisory Council in 1999. The Council's purpose is to advise on the planning and development of a continuum of high quality, culturally sensitive, cost effective, client-centered health care and supportive services for persons with HIV disease and their families.

The Council is responsible for advising ISDH on HIV services. The membership of the Planning Council is designed to include service providers and those infected/affected with HIV.

Core and Supportive Services: Indianapolis TGA Core Services:

HIV Services within the TGA are categorized by core services and supportive services. Core services include the following service areas: outpatient and ambulatory primary medical care, AIDS pharmaceutical assistance, Early Intervention Services (EIS), Medical Case Management (MCM), oral health and outpatient substance abuse services. While supportive services includes Non-Medical Case Management, short-term housing assistance, emergency financial services, legal services, linguistic services, medical transportation, outreach services and psychosocial support services.

Outpatient and Ambulatory Medical care is the provision of professional diagnostic and therapeutic services by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Allowable services include: diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic

conditions, and referral to and provision of specialty care (includes all medical subspecialties). Outpatient and Ambulatory medical care includes the provision of laboratory tests integral to the treatment of HIV infection and related complications.

AIDS Pharmaceutical Assistance (Local) (LPAP) provides for HIV/AIDS medications using a drug distribution system that has a client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening every six months and is consistent with current HIV/AIDS treatment guidelines.

Oral Health services include diagnostic, preventive, and therapeutic dental care that is in compliance with state dental practice laws, include evidence based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, are based on an oral health treatment plan, adhere to specified caps, and is provided by licensed and certified dental professionals

Early Intervention Services includes; HIV Testing and targeted counseling (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referral services; linkages to care; health education and literacy training that enable clients to navigate the HIV system of care and; other clinical and diagnostic services regarding HIV/AIDS, periodic medical evaluations for individuals with HIV/AIDS, and provision of therapeutic measures

The Health Insurance Premium and Cost Sharing Assistance program consists of financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. The insurance should provide comprehensive primary care and pharmacy benefits for low-income clients that provide a full range of HIV medications. This includes premium payments and deductibles on behalf of the client, and providing funds to contribute to clients' Medicare Part C true out-of-pocket (Troop) costs. Part A funding is used to supplement, not supplant, existing federal, state or local funding for Health Insurance Premium and cost sharing assistance.

Mental Health Services provide psychological and psychiatric treatment and counseling services to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Medical Case Management services include a range of client-centered services that link clients with health care, psychosocial, and other services and to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team. The coordination and follow-up of medical treatments is a component of medical case management. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation

and adaptation of the plan as necessary over the life of the client, but at least every 6 months if applicable. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Outpatient Substance Abuse Services provide services under the supervision of a physician or other qualified/licensed personnel. This service may include the use of funds to expand the HIV-specific capacity of programs if timely access to treatment and counseling is not otherwise available. Services are limited to pretreatment recovery readiness program, harm reduction, mental health counseling for anxiety and other disorders associated with substance abuse, outpatient treatment and counseling, opiate assisted therapy, neuro-psychiatric pharmaceuticals, relapse prevention and limited acupuncture services.

2. Supportive Services

Case Management (non-medical) service includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, whereas medical case management does.

Short Term Housing is the provision of short-term housing to agencies or the establishment of voucher programs to assist with short-term expenses related to housing. This is the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the associated fees. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

Emergency Financial services support the short-term provision of programs to assist with emergency expenses related to essential food and utilities. This service is provided to clients with limited frequency and limited periods of time through either short-term payments to agencies or establishment of voucher programs. Direct care payments to clients are not permitted. It is anticipated that clients would utilize one unit of service within a grant year.

Legal Services are provided for HIV-infected persons to address legal matters directly necessitated by their HIV status. Legal services include powers of attorney, living wills, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Part A Program. Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counseling regarding the drafting of (1) wills or delegating powers of attorney, (2) preparation for custody options for legal dependents including standby guardianship, and joint custody or adoption. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. It does not include criminal defense, class action suits unless related to services eligible for funding under the Ryan White HIV Services Program.

Linguistics Services support the provision of interpretation and translation for both oral and written communications. When such services are necessary to facilitate communication between the provider and client, qualified individuals must provide them as a component of HIV care.

Medical Transportation services include conveyance services provided, directly or through a voucher, to a client so that he or she may access HIV-related medical care and/or support services. This service may also be provided by the use of volunteer drivers and/or purchase or lease of agency vehicles for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle. Agencies who are applying to provide this service using a vehicle, the vehicle must have handicap accessibility

Outreach services serve to assist in the identification of HIV+ who are unaware of their HIV status; or identification of HIV+ individuals who are aware of their status so that they may become aware of and enrolled in care and treatment services (i.e., case finding). Outreach services do not consist of HIV counseling and testing or HIV prevention education.

Psychosocial Support services are support and counseling activities, child abuse and neglect counseling, pastoral care, caregiver support, and bereavement counseling. These services include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.

The Ryan White Indianapolis TGA Planning Council is a legislatively mandated component of the Program. The Council conducts planning, decides how to use funds, and works to ensure a system of care that effectively serves all eligible PLWH in the jurisdiction. The Ryan White Planning Council partners with the Ryan White HIV Services Program to develop, prioritize and allocate funding for programs designed to improve health care for PLWH/A in the Transitional Grant Area (TGA). The Council establishes priorities based on need for health services in the TGA, determines the funding amount to be allocated for each service, and creates a comprehensive plan for service delivery. Council members are volunteers, appointed by the Mayor of Indianapolis. Council membership includes PLWH, provider representatives, and other community members. Standing committees of the Council are: Systems of Care, Consumer Access, Quality Management, Priority Setting and Allocations/Needs Assessment, and Membership/Policy & Procedures.

3. Identified Service Needs:

There were a number of documents provided to the Needs Assessment Workgroup to aid in the determination of identified needs, gaps and barriers. Documents reviewed included the TGA 2013 Client Satisfaction Survey Report, the ISDH 2013 Indiana Consumer Report, the ISDH 2013 Indiana Provider Survey Report, the TGA Comprehensive Plan, Part A Needs Assessment Data and the ISDH Comprehensive Plan. Findings from these data sources were used to identify service gaps and funding priorities. Focus areas included provider perceptions of access to HIV-related services in the TGA and the state as a whole, relevance of services for PLWH in the TGA, barriers to seeking and/or remaining in care in the TGA and across the state, self-reported needs of PLWH, and types of services considered to be priorities for PLWH. Additionally, program and fiscal utilization data were referenced where appropriate.

Based on the results of needs assessments and data sources identified earlier, the following services have been identified as most in need for PLWH in order to optimize health outcomes; 1) Case Management (both Medical and non-Medical); 2) Care Coordination; 3) EIS; 4) Health Insurance Premium and Cost Sharing Assistance; 5) Outpatient Ambulatory/Primary Medical Care; 6) Local AIDS Pharmacy Assistance Program; 7) ADAP; 8) Mental Health Services; 9) Housing; 10) Substance Abuse Services; and 11) Medical Transportation

To promote parity as services are planned and implemented, the recipients considered and will continue to consider the unique needs of the populations of special interest: African Americans, women of childbearing age, immigrants, and young adults. These are groups that bear a disproportionate disease burden or face unique challenges to accessing and remaining engaged in care. A summary of survey's indicated important service needs identified by African Americans living with HIV include health insurance, housing assistance, substance abuse, psychosocial services, and medical transportation. Significant needs identified by women of childbearing age included health insurance coverage, mental health services, housing, emergency food assistance, and medical transportation. Among foreign-born persons living with HIV services of importance included access health insurance coverage, interpretation services, transportation, and housing. And service needs identified by young adults living with HIV included health insurance coverage and medical transportation.^{123 124}

The needs assessment workgroup felt it important to identify areas where systematic and social challenges occur and how these challenges impact prevention and care services in Indiana. The group believed it necessary for the Plan needed to address these significant co-factors if the gaps or barriers to services were to be successfully addressed reduced and/or eliminated. The areas of most concern were mental health, substance abuse and addiction, poverty and homelessness, incarceration, geographic isolation, lack of reliable medical transportation and culturally and linguistically appropriate service providers.

Mental Illness/Health:

In the 2013 HIV Services Needs Assessment report, only 9% of the clients sampled identified mental health treatment as their most important non-HIV medical service. However, 26% reported that they had missed work, school, or appointments due to mental stress in the past 30 days. Of these respondents, 8% reported difficulty obtaining mental health services once or more in the past year (an improvement compared to 20% in 2009). However, 54% of the providers surveyed noted that mental health issues hinder their patients' ability to access care.¹²⁵ To address the incidence of mental illness/health among HIV-positive persons goals in the Plan are devised to direct that case management providers screen enrollees for mental health concerns every six months (beginning at enrollment) and refer as mental health services as appropriate; mental health service providers perform an exhaustive psychological assessment prior to initiating treatment and every six months thereafter for as long as the client is in treatment; mental health service providers refer participants for in-patient services when appropriate; and psychosocial support providers regularly screen and refer participants to more appropriate levels of mental health care when indicated. Additionally, it is recommended that the Federal recipients continue to work to locate and establish partnerships with providers that offer services at non-traditional times and locations and are culturally and linguistically appropriate to the populations in their individual jurisdictions.

Addiction:

The 2013 State HIV Services Needs Assessment report showed that only 2% of consumer respondents identified drug and alcohol services as their most important non-HIV medical service need. However, 50% of the providers cited drug and alcohol use as a leading factor in their patients' failure to consistently engage in care; similar results were seen in 2009.¹²⁶

Addiction is a particular concern for the Part A grantee. Substance abuse has been shown to decrease adherence to nutrition or medication regimens for persons with HIV. Furthermore, untreated mental illness often accompanies drug and alcohol abuse and plays an important role in an individual's adherence to medical treatment. Drug and alcohol abuse are also associated with participation in behaviors that put individuals at risk of contracting or transmitting HIV, including engaging in unprotected sex.

One means by which to assess and increase the utilization of this service is to continue to ensure that case management providers screen enrollees for substance abuse issues every six months (beginning at enrollment) and refer to substance services as appropriate; substance abuse treatment providers perform an exhaustive addiction assessment prior to initiating treatment and every six months thereafter for as long as the client is in their care; and treatment providers refer participants for in-patient services when appropriate. Goals in the includes recommendations the Federal recipients continue to work to locate and partner with providers that offer services at non-traditional times and locations and are culturally and linguistically appropriate to the populations in their individual jurisdictions. It is also expected there will be continued efforts to partner with agencies that provide in-patient services to aid clients in achieving optimum health outcomes.

Societal Needs:

The term "societal issues" is used to describe larger community-wide problems that ultimately affect an individual's potential to realize positive health outcomes and is represented by the following:

Poverty and Homelessness:

HIV infection and poverty frequently co-occur. Poverty can be both a risk for and a result of HIV infection. In 2014, the Federal Poverty Level (FPL) for a single person was \$11,670, and the most commonly used income limit for Ryan White services – 300% of the FPL – was \$35,010. Nationally, in the preceding year, only 14.5% of the general population was living below the poverty level.¹²⁷ Within Marion County, however, circumstances were less favorable in 2014; it was estimated that 21.4% of all residents were living below 100% of the FPL.¹²⁸ Unfortunately, Part A service recipients were even more impoverished; during fiscal year 2014, 61.6% were living below 100% of the FPL, another 27.1% were living between 101-200%, and the balance was living between 201-300%.¹²⁹

The 2015 annual count of homeless persons found 1666 homeless individuals in Marion County. On 28 January 2015, the Indiana University Public Policy Institute and the Coalition for Homelessness Intervention and Prevention (CHIP) coordinated the annual Point-in-Time Count of those experiencing homelessness. The count is conducted in accordance with requirements set forth by the U.S. Department of Housing and Urban Development (HUD). HUD requires local counts to estimate the extent of homelessness nationwide. In addition to reporting to HUD, the data collected from the count is used to assess changes over time and identify emerging needs of

those experiencing homelessness in Indianapolis and Marion County at large. The number of individuals found in 2015 decreased slightly compared to the prior year when 1,897 persons were counted. (The 2015 results were more similar to those of 2012 and 2013.) A point-in-time count by definition will not count everyone who experiences homelessness, but this snapshot is the best evidence available to quantify the nature and extent of HUD-defined homelessness in Indianapolis.¹³⁰

In 2014, HOPWA subcontractors in the TGA served a total of 371 households. Of this number, 103 received short-term housing, 239 received long-term housing, and 29 received other types of supportive services. The total cost per unit of assistance for the year was \$1658.03. Black persons constituted the majority of the clients (56.33%) receiving housing assistance from HOPWA.¹³¹

To address the impact of poverty and homelessness on HIV-positive persons in the jurisdiction, programs need to continue to work with EFA and housing assistance service components, and ensure that its case management providers include budget management in the care plans of low-income clients and those with unstable housing. These issues are also address in the goals and objectives section of this document.

Former Incarceration:

Those who have been incarcerated in the past are disproportionately impacted by HIV. The IDOC has a consistent adult inmate population that averages 29,000 with approximately 16,000 inmates being released each year.¹³² Roughly one-third are released into the TGA.¹³³ IDOC tests all inmates for HIV at intake, and has historically diagnosed approximately 300 new HIV cases among inmates HIV annually.¹³⁴ Since approximately 1% of the IDOC inmate population is HIV-positive, an estimated 160 inmates with HIV are released each year.

Inmates who are HIV-positive often find it difficult to entry into the continuum of HIV care upon release. Newly released inmates with HIV face myriad barriers including poverty, homelessness, and addiction.¹³⁵ To address these issues, the Part B grantee entered into a formal agreement with IDOC in 2010 to facilitate the introduction of HIV Care Coordination into the prison setting immediately upon identification of a positive inmate. Existing case management services offered by IDOC are now complemented by the local HIV Care Coordination provider, and services continue for the term of the incarceration, including the entire discharge process. Once released, the former inmate is either fully integrated into the local continuum of HIV care or arrangements are made for services wherever the inmate plans to relocate.

While invaluable for the client, the facilitation for entry into care is extremely time-consuming, both for the HIV Care Coordinator and for ISDH. Each referral requires coordination between the HIV Care Coordination Program Manager at ISDH, OCDR, and the Director of Case Management at IDOC, the facility-level Case Management Supervisor, and the IDOC case manager assigned to the offender. All these connections must be made – and all the necessary releases signed – before the case can be assigned to the local HIV Care Coordinator. Once the assignment is made, ISDH monitors the case until the individual has been successfully integrated into the HIV Care Coordination system. To date, no cost evaluations of this new process have been conducted; however, it is certain that this closely managed and complex process carries a cost much greater than the standard referral into care. To address the impact of incarceration on

HIV-positive persons in the jurisdiction the programs will continue their relationships with IDOC to provide pre-release case management services in the prison setting and to facilitate post-release integration of the inmate into the local continuum of HIV care (using both case management and HE/RR program resources). This will be a long term objective.

Geographic Isolation:

In 2011, 13.4% of the prevalence population lived outside of Marion County. Despite early indications to the contrary, by the end of 2013, this percentage had remained unchanged. However, during the same period, the percentage of Part A enrollees living outside of Marion County had actually decreased from 7.7% to 5.2%.¹³⁶ And while these figures are relatively low, the recipients remain concerned about the serious challenges faced by those living beyond the boundaries of metropolitan Indianapolis.

The majority of the HIV service providers in the TGA are located in Marion County and in urban areas throughout the State. This requires persons with HIV in the rural parts to either commute long distances or to receive services from local providers who do not specialize in the care and treatment of HIV disease. (While the City of Indianapolis provides adequate public transportation in the form of *IndyGo* bus services within Marion County, such options are essentially non-existent in other parts of the TGA and throughout the State, placing low-income persons living in less urban areas at a distinct disadvantage.) In addition to this access and quality issue, residents of less urban areas face increased stigma compared to their urban counterparts. This often serves as a deterrent to disclosure and engagement in care. The goals and objectives of this plan address this concern of geographic isolation on HIV-positive persons in the jurisdiction through the continued allocation of funds for medical transportation services, focusing attention on providers that can provide service to areas outside of the urban areas; continuation of health insurance premium and cost sharing assistance and collaborate with the Part F grantee to identify and provide training and support to willing service providers located in the outlying counties that will increase the workforce development capacity.

Lack of culturally and linguistically service and service providers:

Clients consistently indicate that despite similarities, fundamental differences among people continue to arise from nationality, ethnicity, culture, family background, economic status, and sexual orientation and identity that hamper access in HIV prevention and care. These differences severely impact the health beliefs and behaviors of both clients and providers. The Georgetown University National Center for Cultural Competence states that, “Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States”.¹³⁷ The need for the provision of prevention and care services that are reflective of the populations being served is essential. The communities hardest hit in Indiana are people of color, MSM, substance abusers, and sexual minorities. These are individuals that are also often socially and economically challenged adding to the plight in having equitable access to prevention and care services. In Indiana, outside of the TGA, there are a limited number of Infectious Disease physicians and/or primary care physicians that have the capacity to work with non-English speaking or culturally diverse populations. Additional information is located in the Work Force Development segment of this Plan and the means by which to begin to address these issues are contained in the goals and objectives section of this document.

Identified Service Gaps:

During 2015, 621 residents, or 9.4 per 100,000, were newly diagnosed with HIV and, at year's end, 0.18% of residents were living with HIV. An additional 1,718 residents are thought to be HIV-positive but undiagnosed and unaware of their status increasing the estimated number of PLWH to 13,416.¹³⁸ The greatest concentrations of PLWH are found in urban counties or those parts of the State where universities and/or correctional facilities are located within their boundaries and nearly three out of four (72.8%) Indiana residents living with HIV reside in Marion, Lake, St. Joseph, Allen, Vanderburgh or Clark County (N=8,521), representing the largest urban areas within the state.

The HIV epidemic in Indiana disproportionately affects the central region of the state, which include counties served by the Indianapolis TGA. The Indianapolis TGA represents a 10 county area and despite accounting for only 27.8% of the population in the state of Indiana, the TGA is home to nearly half (48.5%) the state's PLWH and more than a third (36.2%) of those newly diagnosed HIV in Black and 9.8% Hispanic. The Indianapolis TGA first received Part A funding in 2007 to serve PLWH in their jurisdiction.

Accounting for 77% of new (N=479) and 80% of existing (N=9,328) HIV in Indiana, males bear the burden of HIV by sex at birth. Incidence among males is 3.5 times that of females and their prevalence is 4.1 times that of females. Undiagnosed HIV among males is thought to be about 2% higher than that of females.¹³⁹ When considering gender identity, transgender individuals bear the greatest burden. While accounting for less than 2% of new and existing HIV, the rate among transgendered residents is thought to be considerably higher than that of either males or females; especially among male-to-female transgendered persons (rates not calculated due to lack of population data). Research shows that prevalence of undiagnosed HIV among male-to-female transgendered individuals is at least twice that of males or females.¹⁴⁰ The complete epidemiologic profile is discussed in Section 1 A of this Plan.

In a recently completed statewide needs assessment, initial results, indicate gaps in primary medical care, especially in rural areas of the state, health insurance, dental, optical, case management, housing, mental health and substance abuse.^{141 142} Additionally, in 2013, the MCPHD conducted a large scale assessment of needs in the Indianapolis TGA.¹⁴³ Among core medical services the three groups of respondents in the 2013 survey were fairly uniform in their feelings pertaining to insurance premium and cost sharing, primary medical care, and medication assistance; all of these categories were rated high in need. Home health and hospice care ranked among the lowest of needs. Consumers and medical providers both ranked medical case management as most important, while key stakeholders rated this service category as fourth out of 16 service categories. However, medical providers and key stakeholders did agree upon the importance of need for housing and support services.¹⁴⁴

The 2016 statewide needs assessment completed by MATEC found that majority of Indiana's HIV population is aging and living below poverty line. That same assessment reported that the top three barriers to care were: lack of reliable transportation and its availability; did not want others to know their HIV status and could not afford services and/or copays. In addition, many clients reported that they are in need of vision services and copay assistance.¹⁴⁵ In the 2013 statewide needs assessment, results indicated gaps in primary medical care, especially in rural areas of the state, health insurance, dental, optical, case management; housing, mental health and

substance abuse services were identified as critical needs.^{146 147} The results of the MCPHD 2013 Needs Assessment offered similar findings. Those most notable were: among core medical services, health insurance premium and cost sharing, medical case management, primary medical care, mental health services, substance abuse services and medication assistance were rated as in high need, with outpatient ambulatory services being rated as the most important. However, there was disagreement among consumers and medical providers regarding case management. Consumers rated this services the first or second most important, while key stakeholders rated this service category as fourth out of sixteen service categories. Home health and hospice care ranked among the lowest of needs. Consumers and medical providers both ranked case management (medical and non-medical) as most important, while key stakeholders rated this service category as fourth out of sixteen service categories.¹⁴⁸

Local AIDS Pharmacy Assistance was ranked among the top three funding priorities by both providers and consumers,¹⁴⁹ and was reinforced with the preliminary report of the 2016 ISDH needs assessment.¹⁵⁰ In 2013, HIV care provider's ranked mental health care the second most important need¹⁵¹, and 60% of clients ranked mental health care among their top ten priorities¹⁵². Among clients, oral health has been ranked number as one of the most important service¹⁵³. However, there remains a gap in service delivery for those PLWH residing outside of a major urban area.

Medical providers and key stakeholders also agreed upon the importance of housing and support services. The respondent group in the 2013 survey disagreed about access to mental health and substance abuse services. In terms of substance abuse treatment, key stakeholders ranked this as the fourth-highest need, providers noted this in the middle, and consumers ranked this service second to last. Both medical providers and key stakeholders ranked mental health as their second-highest ranked medical service, while consumers ranked it towards the bottom.^{154 155}

Careful consideration was also given to the existing continuum of care, and to the needs of emerging communities, communities of color, rural communities, status-unaware individuals, and the unmet need population. The recipients are working to create programs that alleviate common barriers such as lack of transportation, unstable housing, and emergency financial needs. Moreover, the recipients are seeking to diversify allocations to support other activities – including substance abuse and mental health services – impacting an individual's ability to adhere to treatment and remain in care. Because of its correlation to positive health outcomes, retention in care has become a major objective of the Plan.^{156 157} Support services such as medical transportation and case management have clear benefits in this respect.

Social and Structural Barriers:

The term “societal issues” is used to describe larger community-wide problems and limitations in the continuum of care itself that ultimately affect an individual's potential to realize positive health outcomes. These include the issues surrounding mental health, addiction, poverty, homelessness, former incarceration, geographic isolation, the lack of culturally and linguistically appropriate services and service providers, which have been previously discussed.

Program, Service (Providers) and Client Barriers:

Despite the coordinated efforts of the various grantees, providers and funders, challenges remain to ensure equitable access to these services for all PLWH in Indiana. Those challenges include system, provider and client barriers, as well as societal issues such as poverty, mental health issues, and geographic isolation. The following paragraphs briefly describe a summary of barriers to care and prevention identified for the Indiana jurisdiction. These barriers include the obstacles experienced by the consumer, those facing the providers, and those inherent in the program and the larger system of care or program. Certain obvious cross-category barriers (such as the general limitations necessitated by the amount of the annual funding and that services can only be delivered by a finite number of contracted sub-grantees) are not included in the following description.

Testing and Prevention Barriers:

The CDC recommends that diagnostic HIV testing and opt-out HIV screening should be a part of routine clinical care within all healthcare settings. Yet, routine HIV testing does not include HIV testing that would occur in standard medical clinics, which is where routine HIV testing should occur; this is a function of lack of desire/availability and is not the result of prohibitive state or local legislation. The Indiana Integrated Plan supports CDC's recommendation for routine HIV testing in clinical settings by planning to combine the delivery of early intervention and risk reduction services together in order to expand testing efforts throughout the state of Indiana. However, there are a significant number of barriers regarding HIV testing and prevention.

One of the challenges regarding the care continuum is early identification and entry into care or reentrance into care. Efforts are needed to increase the number of people that are tested and the number of individuals that present positive at the early stage of HIV, rather than AIDS. Testing programs need to expand access to rapid testing in high-risk communities and census tracts where there is an increase in HIV prevalence and STD co-infection. In addition, there is also a lack of consistency in providing outreach to those already living with HIV and to bring them back into care. Other examples of a testing barrier occur when individuals receive their first positive test; individuals must be able to be directly linked to confirmatory testing and, if positive, referred to case management and medical services. While this testing structure appears to be streamlined across entities, in reality, clients are often lost during this process. The Indiana jurisdiction is actively working towards bridging the gap between HIV testing and immediate linkage to medical care. In the meantime, there are many other systemic barriers that are also associated with testing and prevention efforts. These barriers include: 1) testing sites are not accessible due to location, time and/or cultural/linguistic competencies, 2) lack of programs and/or support for HIV negative individuals to remain negative, 3) lack of program or immediate linkage to care, 4) lack of transportation and child support, 5) an insufficient number of DIS to facilitate linkage to care and 6) the need to increase data sharing among all entities.

Aside from the systemic barriers to testing and prevention, there are also provider and consumer barriers as well. Some of the provider barriers for testing and prevention services include: 1) many of the providers that perform testing are disconnected from the system of care and are unaware of the resources necessary to provide timely access to care, 2) identification and locating individuals that are aware of their HIV status, but out of care can become time and resource limited, 3) HIV prevention services are funded by a variety of sources that may or may not be collaborating, 4) not all providers have the capacity to conduct testing, referral, linkage

and health education on site, 5) lack of standard operating procedures and specific parameters between providers, 6) HIV testing is not currently a routine test in all medical facilities or medical providers. On the other hand, from a consumer perspective, some consumers may not be ready to know their status due to fear or stigma related to HIV. Individuals that do know their status may not be at a stage where they are ready to seek out additional medical treatment. Other possible client barriers include: 1) high risk individuals delay or avoid testing due to competing needs, fear, denial and stigma, 2) clients may not return for their HIV test results, 3) medical literacy on behalf of general population, those most at risk and the provider communities; 4) substance use, 5) unstable housing, 6) unmet psychosocial or supportive services, and 7) mistrust of the healthcare system.

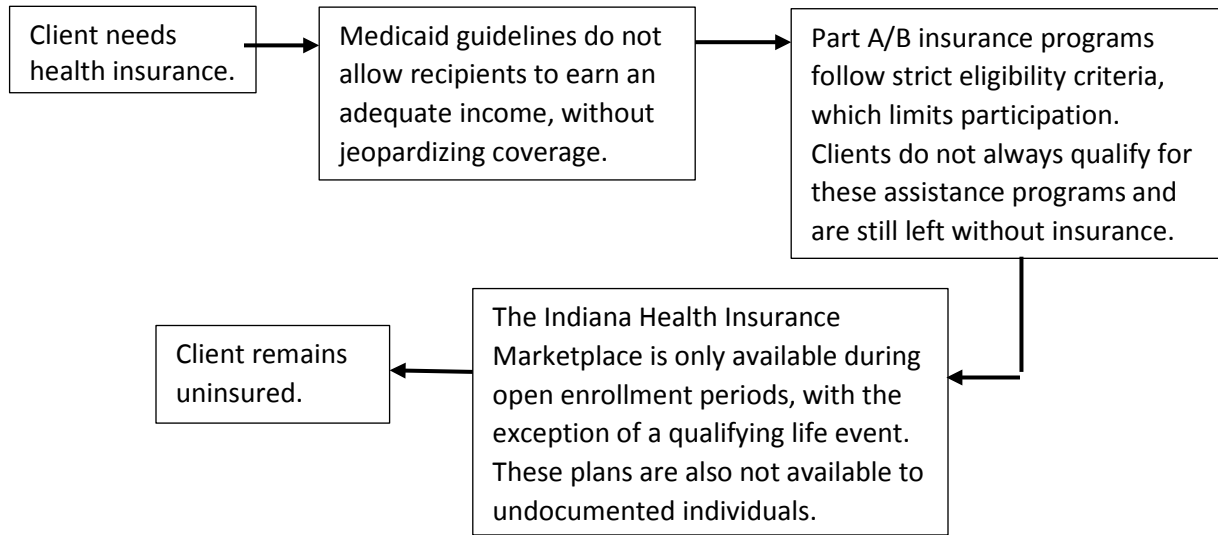
There are also many legal barriers that impact HIV testing and prevention efforts in Indiana. Legal issues primarily relate to identifying, referring, and linking individuals to care who engage in injection drug use (IDU) behaviors. Until very recently, Indiana's paraphernalia laws and pharmacy rules inhibited the ability to establish a successful syringe exchange program (SEP). However, the HIV crisis in Scott County, allowed for emergency response syringe exchange services. Although the SEP law and requirements are restrictive, this was a major success for Indiana. To date, five counties that have applied for a health emergency declaration related to IDU, and submitted requests to ISDH Commissioner for permission to establish a SEP in their respective counties. All five submissions have been approved in Clark, Scott, Madison, Monroe and Fayette counties. There are indications that additional counties are preparing to move forward with declaring health emergencies and will be submitting requests to begin operating SEP as well.

Services System Barriers:

Service system barriers impact medical care at all levels include accessing the monetary means by which to receive services. Health insurance provider networks (including those utilized by Indiana Medicaid and its Healthy Indiana Plan) often prevent consumers from accessing the most appropriate or preferred physicians. Often, facility-based indigent programs for primary care are limited to one large, urban hospital and not geographically accessible to a large percentage of the populations most at need. Although essential to PLWH, public health programs (like those offered by Parts A and B) follow strict eligibility criteria which can limit equitable participation. And Indiana Medicaid guidelines do not allow the recipients to earn an adequate income without compromising or jeopardizing their coverage. Additionally, plans offered through the Indiana Health Insurance Marketplace are only available during "open enrollment" unless the individual can document a qualifying event. These Plans are also not offered to those individuals that are undocumented.

Utilizing medical services at all levels includes having access to health insurance benefits in order to receive specific healthcare services. Health insurance provider networks (including those utilized by Indiana Medicaid and its Healthy Indiana Plan) often prevent consumers from accessing the most appropriate or preferred physicians for routine HIV medical care. The flowchart ([Figure7](#)) below displays many of the barriers clients experience when trying to navigate the insurance landscape in Indiana.

Figure 7: Insurance Barriers



In addition, the ability to access medications is also hampered by health insurance provider networks. Certain health insurance provider networks (including those utilized by Indiana Medicaid and Medicare Part D plans) prevent consumers from accessing the most appropriate or preferred pharmacies which limits consumers' ability to remain adherent to their treatment plan. This is especially true in areas of the jurisdiction where there are a limited number of pharmaceutical HIV providers. Additionally, facility-based indigent programs for pharmaceuticals are limited and most Medicare Prescription Drug Plans have a coverage gap resulting in additional out-of-pocket expenses for consumers. Patient assistance programs sponsored by insurance manufacturers are available for clients who experience gaps in coverage. However, these programs are designed to be a short-term fix until the client is able to find a permanent solution. Indiana also has a Medicare Extra Help program that is available for consumers, yet many do not qualify for this program. These combined insurance barriers place uninsured consumers at extreme disadvantage compared to those who have insurance readily accessible. The lack of access to funding sources to cover medical care also extends to oral health, mental health, substance abuse, and financial emergency assistance for utilities, food and housing.

Having equitable access to competent medical and non-medical case management services also impacts one's ability to access and remain in care. Currently, there is not a consistent delivery of these services and as a result, clients are often confused as to what to expect. Not all of the individual providing this service have the same level of systemic knowledge or expertise regarding eligible services and assisting in accessing those services.

Accessing mental health and substance programs area also hampered by systemic barriers to care. In Indiana a wide disparity exists in the mental health and addiction treatment offered by insurance plans offered through the Market Place or via the Healthy Indiana Plan. As discussed in the workforce development section of this document there are a limited number of providers with the willingness or expertise to treat PLWH that may also have mental health or substance abuse issues. This is especially true for women and/or families. Additionally, many clients are in

need of outpatient mental health and/or substance abuse services, which are not currently covered by Ryan White funding.

Support system barriers also impact accessing and the delivery of emergency services in Indiana most notably in the areas of emergency financial assistance for food and utilities, linguistics, housing and medical transportation. In all instances there is a lack of funding to provide for the overwhelming need. There are limited resources available within most jurisdictions and are time limited and/or have are monetary assistance capitation usage rates and many of the programs are time limited. Additionally, the 75% core medical requirement in the Ryan White Modernization Act severely limits the amount of funding that could be allocated to these services based on need.

Regarding housing, there remains an overall lack of affordable, accessible, adequate and safe low income housing despite the need for such programming. Additionally, most assistance programs are time-limited and do not address the problem of the availability of long term housing or stability in housing. Lastly, a significant number of available housing program impose restrictions that disallow housing for many of our clients, for example those with mental health and/or substance abuse issues. This lack of adequate housing significantly impacts PLWH and their ability to access and/or remain in care.

Provider barriers:

Provider barriers also contribute to limitations on equitable access to medical care and services. The number of infectious disease specialists practicing in the TGA is small outside of Marion County, resulting in high patient volume per provider.¹⁵⁸ And those clients that do not have access to these infectious disease specialists are at distinct disadvantage in receiving equitable care of the same quality as those that do. Past provider surveys have indicated that some General practitioners are often reluctant to treat HIV disease due to its complexity and a lack of sufficient knowledge and training. These professionals can and do provide good primary medical care, but the client must seek alternate medical care for their HIV care.¹⁵⁹

Historically in Indiana access to oral health professionals has been problematic. Either the oral health professional is not “comfortable” with providing care to PLWH or they do not feel they have the expertise to understand the contraindications of medications and treatment with HIV medications. Also, it is often the case that some Oral Health Providers do not accept Medicaid or have very long waiting lists for individuals to access care.¹⁶⁰

Access to mental health and substance abuse services are also impacted by providers. Not all mental health providers are equipped to address issues associated with HIV such as diagnosis, sexuality, sexual identity and chronic illness. Also, in Indiana the number of agencies available to supply these services is very limited, especially for women, and PLWH with families.^{161 162}

In the State of Indiana the continuum of care is very reliant upon medical and non-medical case management and the State’s Care Coordination (non-medical) case management systems. These services are the vehicle that providers access to a means to assist in the financial ability to pay for services and the means by which to identify and access services. However, due to limited funding, providers are often faced with huge caseloads impacting their ability to devote the need time to the medical/non-medical client needs.¹⁶³ Additionally, clients report that not all case managers have the same knowledge level. As a result, accessing care may be dependent on the

case manager with which a client interacts. There appears to be a lack of consistent training provided for case managers to adequately and equitably deliver these services. Regarding medical case managers, there are indications that there are disparities in the degree of training among providers regarding treatment adherence counseling.¹⁶⁴

The lack of access to funding to cover medical care also extends to oral health services, mental health, substance abuse, financial emergency assistance with utilities and food and housing are reported in current needs and survey data.

Consumers Barriers:

Consumers also present unique barriers to their ability to access prevention and/or care services. They are often faced with the reality of being unable to afford primary medical care without assistance which delays entry into care or maintaining an active in care status. The inability to afford health insurance without assistance, the diversity and quality of plans being offered, and the lack of knowledge of the means by which to access health insurance coverage all contribute to a lack of coverage and equitable access to medical care.

Due to the constraints associated with some consumer physical and mental health they are often unable to access appropriate medical care especially if they reside in a geographic medical oasis or no means of transportation. Surveys and needs assessment data indicate that minority consumers often report a mistrust of the medical establishment as their reasoning for not accessing or seeking a care or services. Consumers cite a lack of effective communication with medical providers as a reason for leaving care and decreasing adherence and retention in care.^{165 166}

Additionally, employed consumers report long wait times for appointments at hours convenient to their work schedule and often cannot receive services unless agencies provide non-traditional means of service delivery. Lastly, consumers often experience medical illiteracy in understanding their disease and the need for early and consistent treatment. This is associated with the lack of culturally and linguistically competent services providers, including non-English speaking providers.¹⁶⁷

Consumers also indicate that health care is often compromised by their inability to afford medications, either initially or on a consistent basis, impacting early entry into care or continued care and medication adherence. They often site adverse side effects and drug interactions with adhering to a consistent medical regime. Consumers also realize face financial barriers when seeking oral health care and reportedly do not consider oral health services a priority if they are seeking food and shelter.¹⁶⁸

The impact of both mental health and substance abuse issues and the need for these services is evident in every needs assessment that is being utilized in this document. Yet, clients continue to present barriers to accessing these services. Clients report that the facilities offering these services lack cultural and/or linguistic competency and they do not understand their treatment plans or treatment modalities and they choose to not return to complete treatment. Or they don't seek treatment at all because of these differences. Clients and providers report that many consumers are reluctant to seek or sustain mental health or substance use treatment due to the stigma associated with either diagnosis, especially if coupled with an HIV diagnosis or those at

high risk for HIV infections. Clients and providers also indicate that often clients are not ready for treatment.¹⁶⁹

Consumers are extraordinarily reliant upon medical/non-medical case managers, and care coordinators. Their lack of understanding of the nature of the positions, their limitations, and excessive caseloads, at times, cause clients to not access or terminate these services.

Consumer barriers also impact accessing and the delivery of prevention and care services in Indiana. These include not being aware that such services are available or have the means by which to travel to agencies providing these services. They are also indications that some individuals do not want to know their HIV status.

Even if individuals know where to obtain services they are often hampered by an inability to get to those agencies due to a lack of transportation. Transportation in this jurisdiction is hampered by an inadequate public transportation system. Even where public transportation is available it can be difficult to access for those physical challenged, the aged, women with children, and those that live a significant distance for the point of transportation access.

In housing specifically, many marginalized groups (including women, the chemically addicted, minorities, persons with a history of incarceration, those with mental health issues, poor credit histories, physically challenged, gay men and women, transgendered individuals and those undocumented) frequently report encountering discriminatory housing practices.

E. Data: Access, Sources, and Systems

1. Data for the Epidemiological Overview:

Population data were obtained using information available from the U.S. Census Bureau. Whenever possible, 2015 population estimates were used. Information published by Purcell and colleagues¹⁷⁰ was used to estimate the number of men who have sex with men. HIV data were acquired using information shared between local health departments, Indiana State Department of Health (ISDH), and the Centers for Disease Control and Prevention (CDC). These data are managed using the CDC’s *Enhanced HIV/AIDS Reporting System (eHARS)*.¹⁷¹ Mandatory reporting and a strong health information exchange permits confidence in this data. Geocoding and mapping were performed by the Marion County Public Health Department. Various data sources were used in the evaluation of co-morbidities and all are referenced in the Epidemiological Overview section. The primary sources of these data are listed in [\(Table18\)](#).

Table 18: Primary Data Sources for Co-Morbidities among People Living with HIV in Indiana	
Co-Morbidity	Data Source
Uninsured	U.S. Centers for Disease Control and Prevention Henry J. Kaiser Family Foundation
Mental Health & Substance Abuse	U.S. Substance Abuse and Mental Health Services Administration
Sexually-transmitted infections	U.S. Centers for Disease Control and Prevention
Viral hepatitis	Indiana State Department of Health U.S. Centers for Disease Control and Prevention National Alliance Of State & Territorial Aids Directors C. Everett Koop Institute
Recently incarcerated	Indiana Department of Correction

One of the most challenging tasks of the Epidemiological Overview was quantifying homelessness/insecure housing among people living with HIV. Statewide prevalence could not be determined; however, data availability did make it possible to estimate prevalence among Marion County residents living with HIV. These data sources included:

- U.S. Department of Housing and Urban Development: Housing Opportunities for Persons with AIDS 2014 Performance Profile
- Health & Hospital Corporation of Marion County: Ryan White Information Services Enterprise (RISE) database of Part A/C/MAI service utilization
- U.S. Centers for Disease Control and Prevention: eHARS database
- Indiana University Public Policy Institute: 2015 point-in-time count of the homeless

2. Data for the HIV Care Continuum:

Data for the statewide HIV care continuum were acquired using the same data source as that used for the Epidemiological Overview section (eHARS). While eHARS is a comprehensive surveillance database, receipt of antiretroviral therapy (ART) is not available from this source. Furthermore, while dual reporting of HIV labs is mandated, providers are not required to report ART prescriptions to ISDH or local health departments. Voluntary reporting requires more effort of already taxed HIV care providers leading to inconsistent reporting of ART. An analysis of Ryan White Part B, Medicaid, and HIP 2.0 records could provide partial data, but only for recipients of those services. For this reason, ART was excluded from the statewide continuum of care. The Indianapolis TGA continuum of care was also constructed using eHARS data but was supplemented with ART prescription data obtained from the CAREWare¹⁷² electronic health records of Part A/C/MAI clients allowing receipt of ART to be estimated based on a review of these records and the level of viral load suppression among all others.

3. Data for Human and Financial Resources:

Data used to complete the Human and Financial Resources section of the Integrated Plan included the following items. The Black AIDS Institute HIV Work Survey: *When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce in the United States*. Black AIDS Institute, 2015 (<https://www.blackaids.org/reports/when-we-know-better-we-do-better>). The Black AIDS Institute, in collaboration with the CDC, the Latino Commission on AIDS, and the National Alliance of State and Territorial AIDS Directors, conducted the US HIV Workforce Survey between 2012 and 2013. The 62-question web-based survey was completed by more than 3,600 workers in the HIV field and assessed the knowledge, attitudes and beliefs of the HIV workforce in the United States. Data were reported for three knowledge categories: 1) basic knowledge and terminology, 2) treatment, 3) clinical knowledge (biomedical interventions). The survey report describes the results of the HIV Workforce Survey and includes fact sheets for 16 states and 14 major metropolitan areas with knowledge scores for each of the three knowledge categories, attitudes towards biomedical interventions, and demographic data of the respondents including a work profile. For the Midwest region, the states included in the state fact sheets were Illinois, Michigan, Missouri, and Ohio. Chicago was the only Midwestern metropolitan area included in the fact sheets for major metropolitan areas.

Also utilized was the information from the Data Warehouse, Health Resources and Services Administration; County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States. *JAIDS Journal of Acquired Immune Deficiency Syndromes* Publish. (June 2016, Ahead of Print.); Several maps were created to visualize and analyze data across Indiana. ArcInfo version 10.2.2. was used to develop the maps and geospatial data were downloaded from the U.S. Census Bureau, and included TIGER/Line 2010 Decennial Census files.

Scholarly articles were also referenced that included: Z. Sheff, C. Nowak, H. Maxey. Health Workforce Studies Program Data Report. 2014 Indiana Dentist Workforce. May 2015; Z. Sheff, C. Nowak, et.al. Health Workforce Studies Program Data Report. 2013 Nursing Licensure Survey. January 2015. 7-21-16; C. Lewis., Z. Sheff, T. Zollinger. Health Workforce Studies Program Data Report. Pharmacist Re-licensure Survey Report 2010 Indiana Dentist Workforce. May 2012.; C. Norwood, H. Maxey, T. Kelly. Health Workforce Studies Program Data Report. Indiana Physician Workforce. February 2015. .S. Banti, J. Barclay, et. al. Health Workforce Studies Program Data Brief. Indiana Physicians Assistants. June 2014.; S. Shiver. Rewire. April 2013. “What Is the Role of Disease Intervention Specialists in Preventing STDs?”; Z. Sheff, S. Banti, J. Barclay. Health Workforce Studies Program Data Brief. Indiana Mental Health Professionals 2012 Licensure Survey.

Additional resources for this section were; The Henry J Kaiser Foundation. Medicaid Expansion in Indiana. February 2015 Fact Sheet; *Indiana’s Practical Guide to HIV Resources*;¹⁷³ *Indianapolis Transitional Grant Area 2012 Provider Resource Guide*;¹⁷⁴ Indiana State Department of Health Division of HIV/STD/Viral Hepatitis Webpage and Funding Reports; Ryan White Part A Fiscal and Utilization Reports; CDC Funding Data provided by ISDH; State of Indiana Funding Data provided by ISDH; Medicaid Fiscal and Services Utilization Data; Indiana Philanthropy Alliance Resource Guide.

Needs Assessment Resources

The Needs Assessment workgroup utilized the following documents; the 2013 Client Satisfaction Survey Report (MATEC) for the Indianapolis Transitional Grant Area (TGA); 2013 Indiana Consumer Report – A comprehensive survey/report completed by Dr. Carrie Foote (Indiana University) addressing the State of Indiana’s consumers of HIV services; 2013 Indiana Provider Survey Report – A comprehensive survey/report completed by Dr. Carrie Foote (Indiana University) s addressing the State providers of care for PWLH in Indiana; CDC HRSA Integrated HIV Prevention and Care Plan Guidance; Goals and Objectives of the TGA Comprehensive Plan (Part A). This document references the Indianapolis TGA overall goals and objectives. This includes Administrative, Universal, Core and Support Goals and Objectives; Epidemiologic Profile for the TGA prepared and presented to the Planning Council in June of 2015 to enable them to make decisions for funding in 2016-2017; Service and Fiscal Utilization data of all services in the TGA for Grant Year 2014-2015; Epidemiologic Profile for the TGA, 2016; Service and Fiscal Utilization of Part A and MAI funding for Grant Year 2015-2016 prepared for and presented to the Ryan White Part A Planning Council on July 7, 2016; Part A Needs Assessment Data: Statewide Coordinated State of Need (ISDH 2013) and: ISDH Statewide Needs Assessment Conducted in 2016.

Policies that facilitated and/or served as barriers to the conduct of the needs assessment, including the development of the HIV Care Continuum.

The main barrier encountered regarded the development of the Statewide HIV Care Continuum. The statewide HIV continuum of care was revised from Integrated Plan instructions. A non-standard measure, Received Care, was substituted for the Retained in Care measure. This revision was necessary because ISDH does not yet measure retention in care. ISDH has begun working toward evaluation of retention in care for future reporting needs. In addition, while eHARS is a comprehensive surveillance database, receipt of antiretroviral therapy (ART) is unavailable from this source. Furthermore, while dual reporting of HIV labs by ordering providers and laboratories is mandated, providers are not required to report ART prescriptions to ISDH or local health departments. Voluntary reporting requires more effort of already taxed HIV care providers leading to inconsistent reporting of ART. An analysis of Part B, Medicaid, and HIP 2.0 records could provide partial data, but only for PLWH who receive those services. For this reason, ART is missing in the statewide continuum of care.

Data or information the planning group would like to have had used in conducting the needs assessment including the development of the HIV Care Continuum but was unavailable.

In addition to the item listed above, the workgroups indicated that it would have been beneficial to have the Needs Assessment completed earlier in the process; however, given the time constraints under which the assessment needed completion hampered that process. However, the end result was a comprehensive assessment that proved significant to the development of the goals/objectives associated with this Plan.

Section II: Integrated HIV Prevention and Care Plan

A. GOALS AND OBJECTIVES:

The Integrated HIV Prevention and Care Plan sets forth the goals, objectives, strategies, and suggested activities to address the HIV epidemic in Indiana from 2017 through 2021. The Plan serves as a commitment to collaboration, efficiency, and innovation among and between grantees and community partners, while also responding to the needs of people living with HIV and those at risk for becoming infected with HIV in Indiana.

The plan is composed of five major goals, four of which are found in the National HIV/AIDS Strategy for the United States (NHAS). A fifth goal focusing on financial and other resources was developed and added to the plan to supplement the NHAS goals. Each goal has at least two SMART objectives that serve as the measurable results to be achieved. The NHAS outlines specific indicators of progress for three of its four goals, and these indicators were selected as the objectives for the respective goals within the Plan. Objectives were developed for those goals that did not have corresponding NHAS indicators. Each objective has at least three complimentary strategies which are the approaches through which the objectives will be achieved. Specific activities are detailed under each strategy to provide recommendations for actions through which the objectives can be achieved.

In relation to each activity, targeted populations, responsible parties, timeframes, resources, data indicators, and anticipated challenges and barriers were identified. Colloquial definitions for each activity component are listed below. Additionally, all activities that directly impact outcomes associated with the continuum of care are noted with the associated terms.

In relation to each activity, targeted populations, responsible parties, timeframes, resources, data indicators, and anticipated challenges and barriers were identified. Colloquial definitions for each activity component are listed below. Additionally, all activities that directly impact outcomes associated with the continuum of care are noted with the associated terms.

In relation to each activity:

Diagnosed, Linkage to Care, Retained in Care, ART Use, Viral Suppression: “How does this impact the HIV Care Continuum?”

Targeted Populations: “Who should this impact?”

Responsible Parties: “Who will do this or make it happen?”

Timeframe: “When will this happen?”

Resources: “What do we need to make this happen?”

Data Indicator: “How will we measure this?”

Anticipated Challenges/Barriers: “What might get in the way or prevent this from happening?”

For monitoring progress and implementation outcomes associated with the Plan, the Monitoring and Improvement section details how objectives will be monitored and evaluated over the course of five years.

Goal 1: Reducing new HIV infections

Objective 1: Increase the percentage of people living with HIV who know their status to at least 90% by 2021

Strategy 1: Reduce barriers associated with HIV testing

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Support the modification of laws and policies to promote scientifically-sound policymaking and the de-stigmatization of HIV	Indiana citizens	ISDH; all Ryan White parts; all HIV prevention and care organizations	Ongoing	Political support; lobbyists; health foundations; policy and legislation writers	Number of modified laws/policies; number of proposed law/policy modifications	Rejection of proposed law/policy modifications
Activity 2: Increase the accessibility of testing sites in all communities (i.e., mobile units and non-traditional settings) • Diagnosed	People living in rural and low-resource communities; people with limited access to HIV testing	ISDH; ASOs; CBOs; local health departments	Ongoing	CDC prevention funding; Ryan White EIS funding; community buy-in	Number of tests performed; community-specific positivity rate; number of CBOs, FQHCs, and CHCs providing testing	Limited financial resources; HIV-related stigma; lack of providers and time; lack of community engagement
Activity 3: Streamline HIV testing requirements and establish and distribute clear recommendations for testing providers • Diagnosed	Current and potential HIV testing providers	ISDH, HIV Prevention; MATEC	Annually and ongoing	Staff time; CDC prevention funding; CDC recommendations for HIV testing in clinical and non-clinical settings	Number of organizations/providers reached through distribution efforts	Limited staff time; staff agreement on recommendations to be distributed
Activity 4: Implement strategies to help reduce stigma associated with HIV and HIV testing (i.e., increasing cultural competency of providers) • Diagnosed	Indiana citizens, esp. transgender, non-English speaking, and substance using populations	All HIV testing providers; ISDH; Ryan White parts in relation to EIS	Initially by 2017 and ongoing	Capacity building and training for organizations and HIV testers; MATEC	Number of trainings and capacity building efforts; number of HIV tests performed	Insurmountable stigma in communities; lack of community engagement; disengaged providers

Strategy 2: Reduce barriers associated with HIV testing						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Develop and implement creative and efficient marketing and educational campaigns that utilize a variety of methods and messages about HIV to engage Indiana citizens	Indiana citizens; people living in communities of highest risk; locally defined high-risk HIV negative individuals	ISDH, Ryan White Part A, ASOs, CBOs, CAGs, local health departments, schools, universities, other related gov't and community partners	Ongoing	Funding (any relevant source), capacity building and training, strategies to accurately measure effectiveness of specific campaigns	Number of people engaged in HIV services as a result of marketing and educational campaigns	Limited funding; limited staff capacity and knowledge; difficulty ensuring consistent and scientifically-sound messages; statewide emphasis on abstinence
Activity 2: Ensure all current and potential HIV prevention and care providers are knowledgeable and have access to the most updated recommendations	Current and potential HIV prevention and care providers	ISDH, Ryan White Part A, MATEC, DIS	By 2017, follow-ups annually	Provider buy-in; funding (from relevant source); capacity building and training for providers; HIV prevention, care, and treatment recommendations; staff time; efficient methods of distribution	Number of organizations/providers reached through distribution efforts; number of trainings provided/capacity building events	Provider buy-in; difficulty engaging potential providers; limited staff time
Activity 3: Increase training and continuing education opportunities for all HIV prevention and care providers, including non-traditional providers (i.e., peers, primary care)	Current and potential HIV prevention and care providers	ISDH Prevention, all Ryan White parts, MATEC	By 2018 and ongoing	Updated training and educational materials; training staff; funding for training and capacity building; agency/provider engagement	Number of individuals trained annually; number of trainings conducted; number of individuals receiving continuing education; outcomes of testing site evaluations/audits	Inconsistency in curricula; difficulty determining who should receive training/continuing education and from who; limited funding; limited training staff capacity

Strategy 3: Increase the capacity for HIV testing statewide						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Continue to implement data-supported mapping to identify areas of greatest need across the state	Indiana citizens; esp. people living in communities of high HIV incidence	ISDH HIV Surveillance; Ryan White parts	Annually and ongoing	CDC HIV surveillance funding; Ryan White Part A funding; staff time; epi data and mapping technology	Yearly development of state and regional maps for service priority setting	Limited staff time; incomplete data or other data-related issues; inconsistent definitions and processes between the State and Ryan White Part A
Activity 2: Expand routine testing in clinical settings <ul style="list-style-type: none"> • Diagnosed 	Clinical settings in communities of highest risk; clinical settings in low resource areas; pregnant women	ISDH HIV Prevention; all Ryan White parts; MATEC; clinical settings	By 2018 and ongoing	CDC prevention funding; Ryan White EIS funding; capacity building and training for staff; support for billing and reimbursement	Number of clinical settings providing routine HIV testing; number of people tested for HIV in clinical settings	Lack of interest and capacity among clinical providers; limited funding; difficulty billing for HIV testing; variability in clinical settings and capacity to implement program
Activity 3: Expand targeted testing in community settings <ul style="list-style-type: none"> • Diagnosed 	People living in communities of highest risk; locally defined high-risk HIV negative individuals	ISDH HIV Prevention; Ryan White Part A; CBOs, ASOs	By 2018 and ongoing	CDC prevention funding; Ryan White EIS funding; capacity building and training for implementation staff	Number of tests among targeted population (community specific); agency-level positivity rate	Limited funding; limited ability to truly target testing efforts; limited staff capacity; lack of engagement among high-risk populations; HIV-related stigma
Activity 4: Promote service integration to incorporate the offering of HIV testing with other related services (i.e., STD screening) <ul style="list-style-type: none"> • Diagnosed 	Indiana citizens; HIV, STD, and other service providers	ISDH HIV Prevention and STD; all Ryan White parts; MATEC; DIS; STD clinics; communicable disease programs	By 2018 and ongoing	CDC funding; Ryan White EIS funding; capacity building and training for implementation staff	Number of integrated service entities	Limited funding; limited staff capacity and knowledge; lack of appropriate medical service provision agreements
Activity 5: Allow for greater flexibility in HIV testing sessions, including testing technology options <ul style="list-style-type: none"> • Diagnosed 	Grant-supported HIV testing sites; Indiana citizens	ISDH HIV Prevention; HIV testing providers; Ryan White parts	By 2017	CDC prevention funding; training for HIV testing staff; various testing technologies and supplies; CDC recommendations for HIV testing	Assessments of ISDH-supported testing sites' ability to meet community needs relating to testing sessions and technologies; testing rate	Resistance to modifying or updating testing processes and technologies; limited funding; significant increase in training needs; lack of adequate supplies; increased fear relating to exposures via blood-based testing

Objective 2: Reduce the number of new HIV/AIDS diagnoses by at least 25% by 2021

Strategy 1: Address the social determinants of health that may play a role in disease transmission

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
<p>Activity 1: Increase statewide capacity to address the mental health needs of people living with and at high risk for HIV infection</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH with mental health needs; individuals at risk for HIV infection with mental health needs	ISDH; all Ryan White parts; CBOs, ASOs, and medical providers; other gov't agencies	By 2018 and ongoing	Mental health providers; community buy-in; funding; provider education and training specific to high-risk and HIV-infected populations	Number of PLWH engaged in mental health care; number of mental health providers in high-risk communities	Community and provider buy-in; limited and restricted funding; stigma surrounding mental health care; disengaged consumers
<p>Activity 2: Increase statewide capacity to address the substance use of people living with and at high risk for HIV infection</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH who use substances; individuals at risk for HIV infection who use substances	ISDH; all Ryan White parts; CBOs, ASOs, and medical providers; other gov't agencies	By 2018 and ongoing	Engagement with substance use treatment providers; unrestricted funding; community buy-in; increased in-patient treatment options; SEPs	Number of PLWH engaged in substance use treatment; number of substance use providers in high-risk communities	Community and provider buy-in; limited and restricted funding; stigma surrounding substance use and treatment; disengaged consumers; drug-saturated communities
<p>Activity 3: Increase statewide capacity to improve the housing status of people living with and at high risk for HIV infection</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH with housing needs; individuals at risk for HIV infection with housing needs	ISDH; Ryan White Part A; CBOs, ASOs, and medical providers; Veterans Affairs; other gov't agencies	By 2018 and ongoing	Increased gov't assisted housing options; funding; collaborations with other housing assistance entities	Numbers of PLWH with met/unmet housing needs; % of housing needs met via funded agencies	Limited funding and housing options; income restrictions; community and agency buy-in; lack of collaboration between housing assistance entities; competing priorities
<p>Activity 4: Increase statewide capacity to address the educational and employment needs of people living with and at high risk for HIV infection</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH with education/employment needs; individuals at risk for HIV infection with education/employment needs	ISDH; Ryan White Part A; CBOs, ASOs, and medical providers; other gov't agencies; other education and/or employment assistance programs	Ongoing	Funding; trained education and employment specialists; GED courses and tutoring services; business attire support; resume/interview prep; development of peer employment programs for funded agencies	% of education and/or employment needs met via funded agencies	Limited and restricted funding; lack of consumer interest; limited specialists to meet needs; community and agency buy-in; lack of collaboration among agencies and other education/employment assistance programs

<p>Activity 5: Increase statewide capacity to address other basic needs (i.e., food, clothing, utility assistance, etc.) of people living with and at high risk for HIV infection</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH with basic needs; individuals at risk for HIV infection with basic needs	ISDH; Ryan White Part A; CBOs, ASOs, and medical providers; other gov't agencies	Ongoing	Expanded collaborations with basic needs assistance organizations; funding; greater capacity to meet basic needs through existing funded agencies	Number of partnerships developed to meet basic needs of people living with and at high risk for HIV	Limited and restricted funding; limited organizations for partnerships in rural areas; competing priority populations
Strategy 2 : Increase knowledge and availability of preventative interventions for populations at highest risk and people living with HIV						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Expand condom distribution efforts	PLWH; people at highest risk for becoming infected with HIV or other STDs	ISDH HIV Prevention; HIV/STD testing sites; HIV/STD treatment sites; ASOs and CBOs	By 2017 and ongoing	Community buy-in; development of creative condom distribution strategies; engagement with non-traditional condom distributors; funding allocated for condom purchasing	Number of condoms distributed; number of condom distribution sites	Limited funding; state emphasis on abstinence; difficulty monitoring distribution amounts
Activity 2: Continue to support the implementation and utilization of syringe exchange programs (SEP)	People in communities with high rates of injection drug use; people in communities of high incidence of HIV/HCV	ISDH; Ryan White Part A; local health departments; county officials	Ongoing	Unrestricted funding; continued policy support; education and training for SEP staff; community engagement	Number of SEPs; number of SEP participants; amount of harm reduction supplies distributed; number of counties applying for SEP	Funding restrictions and limited local-level funding options; possible changes in state law and policies surrounding SEPs; distrust among potential SEP participants
Activity 3: Explore and implement behavioral interventions for high-risk HIV-negative populations	High-risk HIV-negative populations; people living in communities of high HIV and STD incidence	ISDH HIV Prevention; CBOs, ASOs, and other prevention providers	Ongoing	Evidence-based interventions for high-risk HIV-negative populations; funding and staff for implementation	Number of high risk individuals engaged via interventions	Limited funding, staff, and staff time; disinterest among target population(s)

<p>Activity 4: Explore and implement behavioral interventions for people living with HIV (Prevention with Positives), especially those that emphasize treatment adherence to achieve viral suppression</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH	ISDH HIV Prevention; CBOs, ASOs, and other prevention providers	Ongoing	Evidence-based interventions for PLWH; funding and staff for implementation; engagement of medical care and case mgmt providers as potential facilitators	Number of PLWH engaged via interventions; rates of viral load suppression; improvements in viral load among PLWH, esp. PLWH engaged in interventions	Limited funding, staff, and staff time; disinterest among target population; difficulty achieving viral suppression; difficulty monitoring viral load changes associated with intervention participation
<p>Activity 5: Increase efforts to support ART use and viral suppression among pregnant women living with HIV</p> <ul style="list-style-type: none"> • ART Use, Viral Suppression 	Pregnant women living with HIV	ISDH; all Ryan White parts; CBOs, ASOs; HIV medical care providers; OB/GYN and other prenatal care providers	Annually and ongoing	Engaged providers at all levels; ART adherence interventions targeting pregnant women; provider education and training	Number of pregnant women living with HIV who are prescribed ART; number achieving viral load suppression; decrease in mother-to-baby transmission	Difficulty reaching pregnant women not engaged in prenatal care; competing provider priorities; undocumented women; barriers associated with cultural and linguistic competency
<p>Activity 6: Concentrate HIV prevention efforts in communities of highest risk</p>	People living in communities at highest risk for HIV infection	All grantees and community partners	Annually and ongoing	Regularly defined high-priority communities and populations; funding; creative solutions for difficult to reach people and places	Maintenance and expansion of HIV prevention efforts in communities of highest risk; regular evaluation and defining high risk communities	Difficulty reaching consensus on high-risk communities; difficulty relying on methods other than HIV incidence/prevalence mapping; potential to under-support areas with limited existing need

Strategy 3: Increase knowledge and availability of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Provide education, guidance, and training for potential prescribers of PrEP and PEP	Existing and potential PrEP and PEP prescribers; pharmacists	ISDH HIV Prevention; Ryan White parts; MATEC	Annually and ongoing	Regularly updated educational materials on PrEP and PEP; provider buy-in and time; training resources and funding to support materials	Number of PrEP/PEP prescribers; number of providers reached through distribution efforts; number of trainings and/or educational opportunities provided	Provider buy-in; difficulty engaging potential providers; limited staff time; limited funding
Activity 2: Implement pilot studies to collect Indiana-specific data on PrEP and PEP usage	Existing and potential PrEP and PEP prescribers/agencies	ISDH HIV Prevention; MATEC; ASOs/CBOs; relevant medical providers	By 2018 and ongoing	Development of data needs for strong pilot studies; data from existing PrEP/PEP prescribers; data from PrEP/PEP users; funding to support research needs; engaged agencies and providers	Number of pilot studies initiated and completed; IN PrEP and PEP prescribing and usage data; completion of meaningful reports to help support future PrEP/PEP programs	Prescriber, agency, and user engagement in pilot study process; competing priorities and limited time; limited funding and resources; limited existing PrEP/PEP usage in IN; mixed support of PrEP/PEP efforts
Activity 3: Explore funding options to further support the use of PrEP and PEP	Existing and potential PrEP and PEP prescribers, agencies, and users	ISDH HIV Prevention; all Ryan White parts; HIV prevention and care providers and agencies	Ongoing	Unrestricted funding; creative solutions for funding PrEP and PEP; stronger understanding of insurance coverage and limitations	Securing of funding to be allocated for PrEP/PEP; development of other solutions to fund PrEP/PEP efforts if funding cannot be secured	Limited options to fund PrEP and PEP; difficulty overcoming conflicting beliefs about the benefits/risks of PrEP and PEP; eligibility concerns

Activity 4: Support full coverage of HIV preventive medications with the Department of Insurance and other insurance stakeholders	Department of Insurance; insurance providers	ISDH; all planning bodies; advocacy groups	Annually and ongoing	Development of a proposal highlighting insurance needs relating to preventive medications; engagement with the DOI and other insurance stakeholders; coordinated response among HIV prevention and care providers	Initiation and completion of proposal; increased communication with the DOI and other insurance stakeholders; improvements in insurance coverage options relating to PrEP and PEP	Lack of engagement with DOI and other insurance stakeholders; prolonged and complex processes to implement changes; buy-in among all key parties
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Goal 2: Increasing access to care and improving health outcomes for people living with HIV

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85% by 2021.

Strategy 1: Increase the number, diversity, and capacity of medical providers who serve PLWH

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Identify geographical gaps relating to HIV medical care providers via mapping	Indiana citizens, esp. rural communities	ISDH and Ryan White Parts	Annually	GIS mapping, epi data, cooperation of HIV medical care providers	Completion of a map each year	Collecting and reporting accurate data; difficulty defining concepts for mapping
Activity 2: Increase the number of available providers of HIV medical care <ul style="list-style-type: none"> Linkage to Care, Retained in Care 	PLWH with limited access to HIV medical care; primary medical care providers; nurses; medical students and residents	ISDH, Ryan White parts, universities, healthcare settings	Initially by 2018 and ongoing, as needed	Funding or incentives; training and educational opportunities; MATEC; provider and university buy-in	Number of HIV medical care providers; HIV care delivery among primary care providers	Lack of interest in HIV care provision; limited training capacity; competing priorities among providers; limited options for incentives
Activity 3: Strengthen the current provider workforce to ensure high quality HIV care <ul style="list-style-type: none"> Linkage to Care, Retained in Care 	HIV medical care providers; PLWH	ISDH, Ryan White parts, and MATEC	Ongoing	Training and educational material; service utilization data; patient satisfaction data	Improved patient satisfaction with services; unmet need outcomes	Limited training capacity; staff time; limited resources to support ongoing capacity building

Strategy 2: Ensure initial healthcare coverage for people newly diagnosed with HIV						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Increase the number of insurance enrollment specialists with HIV expertise who can assist with applications and enrollment processes <ul style="list-style-type: none"> • Linkage to Care, Retained in Care 	Uninsured or underinsured PLWH	ISDH, Ryan White parts, case management sites	To be reviewed annually, as needed	Funding for positions, appropriate and ongoing training for providers, buy-in of insurance companies, partnerships between organizations	Number of HIV insurance enrollment specialists; number of applications/enrollments completed; number of PLWH who are insured	Limited funding; logistical barriers; ever-changing insurance landscape; difficulty to meet ongoing training needs; restrictive capacity of specific insurers; change in administration
Activity 2: Increase the number of Ryan White enrollment sites <ul style="list-style-type: none"> • Linkage to Care, Retained in Care 	Rural communities; non-traditional enrollment sites; PLWH	All Ryan White parts	By 2018 and ongoing, as needed	Capacity building resources; training and educational materials; training staff	Number of enrollment sites; number of eligible clients enrolled	Funding limitations; lack of capacity, esp. among non-traditional enrollment sites; difficulty meeting training needs
Activity 3: Increase the number of eligible clients that are enrolled in Ryan White programs <ul style="list-style-type: none"> • Linkage to Care, Retained in Care 	Program-eligible PLWH	All Ryan White parts	Ongoing	HRSA resources; eligibility documentation; education; partnerships with non-Ryan White funded providers	Number of clients actively enrolled in Ryan White programs	Challenges with recertification; lack of appropriate documentation for enrollment or recertification; transportation barriers for clients; changing insurance landscape
Strategy 3: Develop and implement seamless linkage to care processes and programs to serve people who are newly diagnosed with HIV						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Develop capacity and improve data collection and reporting to effectively measure linkage to care <ul style="list-style-type: none"> • Linkage to Care 	ISDH and Ryan White parts	ISDH and Ryan White parts	Initially by 2017 and ongoing	Epi data, shared definitions and standards of measurement, training for those collecting and reporting linkage to care data	Epi outcomes; development and continued use of shared definitions and standards of measurement	Buy-in from existing programs and providers; reporting issues; difference in definitions; territoriality, difficulty with change

<p>Activity 2: Develop a procedural flow for post-diagnosis to ensure appropriate and timely linkage to care</p> <ul style="list-style-type: none"> • Linkage to Care 	Newly diagnosed PLWH	ISDH, Ryan White parts, organizations facilitating linkage to care	Initially by 2017, modifications as needed	Buy-in and participation from all involved parties; models of procedural flow to reference; additional DIS	Development and implementation of a linkage to care procedural flow; linkage to care epi outcomes	Funding, esp. for DIS positions; agreeing on a reference model; consistent and ongoing training; difficulty changing existing processes; navigating changing roles and processes; establishing consistency
<p>Activity 3: Develop capacity and implement the use of linkage specialists and/or HIV navigation services statewide</p> <ul style="list-style-type: none"> • Linkage to Care 	Newly diagnosed PLWH	ISDH, Ryan White parts, organizations facilitating linkage to care	Initially by 2017, modifications as needed	Targeted funding; community planning group buy-in; buy-in and participation from all involved parties; agency buy-in	Increase number of linkage specialists and/or navigation services across the state; linkage to care epi outcomes; comparison of location of diagnosis versus linkage to care, also accounting for time	Limited and restricted funding; limited capacity of sites, esp. testing sites; consistent and ongoing training and capacity building; blurred roles between different providers; cultural and linguistic competency and appropriateness to serve all populations

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90% by 2021.

Strategy 1: Strengthen HIV case management programming and services

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
<p>Activity 1: Expand medical and non-medical case management capacity statewide</p> <ul style="list-style-type: none"> • Linkage to Care, Retained in Care 	PLWH	ISDH, all Ryan White parts, partnering organizations	By 2017 and evaluate on an ongoing basis	Funding to support new and existing positions; funding for wage increases and initial and ongoing training; innovation in defining case management responsibilities; shared definitions of medical and non-medical case management	Increased number of case managers; caseloads per case manager; number of case management sites	Funding; capacity and logistics of case management providers; training needs; accommodating differences between agencies of different sizes and capacities; limited partnership options in rural areas; community buy-in

<p>Activity 2: Develop and implement ongoing professional development for all HIV case managers</p> <ul style="list-style-type: none"> • Retained in Care 	HIV case managers	ISDH, all Ryan White parts, and partnering organizations	By 2017 and ongoing	Funding to support professional development; training curriculum and training staff; prof. development opportunities; organizational support; system to track ongoing prof. development	Number of trainings and professional development opportunities; number of case managers who access professional development	Funding; organizational participation and buy-in; staff retention issues; lack of beneficial training opportunities; difficulty tracking professional development
<p>Activity 3: Implement strategies to reduce HIV case manager turnover</p> <ul style="list-style-type: none"> • Retained in Care 	HIV case managers	ISDH, all Ryan White parts, and partnering agencies	By 2017 and ongoing	Competitive wages and benefits; organizational evaluations to assess org. health and morale; consistent hiring standards; initial and ongoing training and career support; competent leadership	Reduction of case management staff turnover; staff retention, including between organizations	Sufficient funding; training and capacity building needs; organizational buy-in; attitudes toward case management and its worth; lack of consistent hiring standards
<p>Activity 4: Explore the use of treatment adherence interventions and other Prevention with Positives strategies via HIV case management</p> <ul style="list-style-type: none"> • ART Use, Viral Suppression 	PLWH who access HIV case management services	ISDH, all Ryan White parts, and partnering agencies	By 2017 and ongoing	Supportive infrastructure; capacity building and trainings; partnerships with pharmacies and other key providers; reference existing models of similar integration; options for technology-based methods	Assessment of partnering organizations to determine preferences; development of a proposed model	Difficulty adapting to change; hiring staff members with appropriate expertise; funding to support integrated teams and networks to support treatment adherence and case management

Strategy 2: Ensure continuity of healthcare coverage and access to care for PLWH						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Establish cross-agency collaboration to facilitate enrollment of clients shared between care coordination/case management agencies <ul style="list-style-type: none"> • Retained in Care 	Case management and HIV care sites	ISDH, Ryan White parts, community partners, healthcare entities	Initiate process by 2017, continue as needed	Secure communication systems; collaborative memorandums of understanding; shared patient confidentiality agreements; legal consultation	Timeliness of enrollment and recertification; number of collaborative agreements between agencies	Lack of appropriate technology; buy-in from providers at collaborating agencies; establishing and maintaining consistency and effective processes; fears and existing policies on data sharing and confidentiality
Activity 2: Explore use of online applications and recertifications <ul style="list-style-type: none"> • Linkage to Care, Retained in Care 	PLWH; HIV care providers	All Ryan White parts	Initially by 2017 and ongoing	Encrypted software; funding for technology needs; IT support; HIPAA considerations; training and education	Timeliness in processing applications and recertifications; number of applications and recertifications received	Lack of access to technology; aversion to technology; fears and policies surrounding data and confidentiality; difficulty establishing an appropriate system
Activity 3: Support research that uses mobile technology to send reminders for HIV appointments, including enrollment/renewals <ul style="list-style-type: none"> • Retained in Care 	PLWH; HIV care providers	ISDH and Ryan White parts	Initially by 2019 and ongoing	Funding; IT support; secure systems; HIPAA training, esp. for mobile technology	Retention in care data; timeliness in processing applications and recertifications	Confidentiality concerns; lack of technological resources; restricted funding; buy-in from providers and clients
Activity 4: Develop capacity and improve data collection and reporting to effectively measure retention in care <ul style="list-style-type: none"> • Retained in Care 	ISDH and Ryan White parts	ISDH and Ryan White parts	Initially by 2017 and ongoing	Epi data, shared definitions and standards of measurement, training for those collecting and reporting retention in care data	Epi outcomes; development and continued use of shared definitions and standards of measurement	Buy-in from existing programs and providers; reporting issues; difference in definitions; territoriality, difficulty with change

Activity 5: Explore options for mobile and/or technology-based HIV care provision <ul style="list-style-type: none"> • Retained in Care 	PLWH who have limited access to HIV care, esp. those in rural communities	ISDH and Ryan White parts	Determine options and feasibility by 2018; pilot by 2019; expansion based on outcomes	Existing models for review; training support for all parties; informational security; culturally and linguistically competent providers and participants; funding	Report/proposal prepared to present options and feasibility of mobile and/or tech-based HIV care provision	Security concerns; general illiteracy surrounding tech-based care and systematic changes; cost/benefit analysis; buy-in from agencies and supporting organizations; difficulty determining feasibility and potential use rates
Activity 6: Increase transportation services for ongoing access to HIV medical care <ul style="list-style-type: none"> • Linkage to Care, Retained in Care 	PLWH who have transportation needs	ISDH, all Ryan White parts, and partnering organizations	By 2017 and ongoing, as needed	Agencies that provide any form of support for transportation services; insurance partnerships; unrestricted funding	Increase in diversity of transportation services provided statewide; review of gaps in HIV medical care visits among PLWH	Limited transportation options, esp. public transportation; funding limitations and restrictions; considerations for urban versus rural communities

Strategy 3: Support the additional medical and social needs of PLWH that will promote retention in HIV medical care

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Implement routine screening, monitoring, and treatment of non-HIV co-morbidities and other healthcare needs <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH	Healthcare providers	By 2017 and ongoing	Models of integrated and holistic care; comprehensive care clinics and providers; data on co-morbidities among PLWH; data on patient healthcare needs	Co-morbidity incidence among PLWH; screening rates; patient needs assessment outcomes	May not reach those PLWH who are not engaged in HIV medical care; unclear roles and responsibilities among care providers; data collection and evaluation
Activity 2: Implement routine screening and treatment for opportunistic infections <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH	Healthcare providers	By 2017 and ongoing	Competent healthcare providers; medical supplies for screening and treatment; patient assistance to support opportunistic infection care	Opportunistic infection screening rates; incidence rates of opportunistic infections	Reporting lags; lack of reporting opportunistic infections; inconsistent care; may not reach those PLWH who are not engaged in HIV medical care

Activity 3: Support social determinants of health that may impact retention in care <ul style="list-style-type: none"> • Retained in Care 	PLWH who risk falling out of HIV care	ISDH, all Ryan White parts, CBOs, ASOs, and other partnering organizations; additional supportive service entities	Ongoing	Appropriate identification of needs; funding and referral resources; collaborative partnerships to help meet client needs	Retention in care among PLWH; usage of support services	Having appropriate resources; referral options; funding limitations and restrictions; client priorities and understanding of resources
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Objective 3: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80% by 2021.

Strategy 1: Reduce barriers for PLWH to begin and stay on antiretroviral therapy (ART)

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Ensure all people living with HIV in Indiana are eligible for and have access to treatment <ul style="list-style-type: none"> • Linkage to Care, Retained in Care, ART Use, Viral Suppression 	All PLWH	ISDH and all Ryan White parts	By 2017 and ongoing	ISDH; Ryan White parts; planning bodies; insurance companies; staff to support insurance enrollment and other needs of PLWH; competent service providers	Increase in eligible PLWH who have healthcare coverage; increase in clients being linked to appropriate services; improved linkage to and retention in care measures	Cultural competency and language barriers; limitations based on geographic location; eligibility restrictions; limited resources; network and formulary restrictions; provider competency limitations
Activity 2: Increase accessibility to pharmacies and prescription delivery options for people living with HIV <ul style="list-style-type: none"> • Viral Suppression 	All PLWH	ISDH and all Ryan White parts	By 2017 and ongoing, as needed	Funding; partnerships with pharmacies and pharmacists; patient-level data on prescription pick-up and delivery needs	Number of partnering pharmacies and pharmacists; tracking of patient prescription receipt; viral suppression rates	Limited and restricted funding; insurance limitations on pharmacies and delivery programs

Activity 3: Assess and address competing health-related and social priorities to HIV care for PLWH <ul style="list-style-type: none"> • Retained in Care 	PLWH who risk falling out of HIV care or not achieving viral suppression	ISDH, all Ryan White parts, CBOs, ASOs, and other partnering organizations; additional supportive service entities	Ongoing	Appropriate identification of needs; funding and referral resources; collaborative partnerships to help meet client needs	Retention in care among PLWH; usage of support services; viral suppression rates	Having appropriate resources; referral options; funding limitations and restrictions; client priorities and understanding of resources
Strategy 2: Increase the capacity of medical and other professional stakeholders who serve PLWH to appropriately prescribe and administer ART						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Increase provider education on the most current treatment and monitoring guidelines for HIV care <ul style="list-style-type: none"> • ART Use, Viral Suppression 	HIV care providers in all capacities	ISDH, Ryan White parts, and MATEC	By 2017 and ongoing	Updated HIV treatment and monitoring guidelines; training and educational materials; provider buy-in	Number of providers who receive training and/or education; number of training and/or educational opportunities; ART use outcomes; retention in care outcomes	Competing priorities among providers; limited staff time; developing and maintaining appropriate training and educational resources; limited ability to enforce recommendations
Activity 2: Develop capacity to assess, treat, or refer PLWH for mental health and/or substance abuse treatment services when appropriate <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	HIV medical care providers; primary care providers; HIV case managers	ISDH and Ryan White parts	Ongoing	Appropriate assessment tools; training and educational materials; strong referral networks; service utilization data; patient needs assessment data	Mental health and substance use disorder screening rates; service utilization rates	Stigma surrounding mental health and substance use; lack of incentive for screenings; limited referral networks; insurance limitations
Activity 3: Engage pharmacies to support treatment adherence among PLWH <ul style="list-style-type: none"> • Viral Suppression 	Pharmacies and staff; PLWH	ISDH and Ryan White parts; pharmacies and staff, esp. specialty pharmacies	By 2018 and ongoing	Relationships with key stakeholders; buy-in from pharmacies and pharmacists; cooperation from insurance providers; appropriate educational materials for pharmacies; support the use of brick-and-mortar pharmacies	Increased collaboration with pharmacies and pharmacists; viral suppression	Insurance restrictions; competency concerns; disengaged pharmaceutical providers in relation to HIV care

Activity 4: Engage mental health providers who treat PLWH to support HIV treatment adherence <ul style="list-style-type: none"> Viral Suppression 	Mental health providers; PLWH who access mental health care	ISDH and Ryan White parts; mental health providers, esp. those supported via Ryan White	By 2018 and ongoing	Relationships with key stakeholders; buy-in from mental health providers; cooperation from insurance providers; appropriate educational materials for providers	Increased collaboration with mental health facilities and providers; viral suppression	Funding concerns; availability of mental health providers; disconnect from HIV treatment needs as part of mental health care
Strategy 3: Increase knowledge and availability of support systems that encourage HIV treatment adherence						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Explore options and implement evidence-based interventions that support treatment adherence among people living with HIV <ul style="list-style-type: none"> Viral Suppression 	PLWH	ISDH, all Ryan White parts, and supporting organizations	By 2017 and ongoing	Existing evidence-based interventions to support adherence; CDC and HRSA suggestions; review of other treatment models	Intervention of evidence-based intervention(s) to support HIV treatment adherence and viral suppression	Cost and funding; buy-in; resistance to change current methods; flexibility to meet needs of urban and rural settings, as well as varying adherence needs of populations
Activity 2: Explore the implementation of targeted medical case management services <ul style="list-style-type: none"> Retained in Care, Viral Suppression 	PLWH who are not virally suppressed; PLWH with gaps in receiving ART; PLWH not retained in care	ISDH and Ryan White parts; HIV case managers	By 2018 and ongoing, as needed	Funding; systems to efficiently track PLWH who are not virally suppressed, have ART gaps, or are not retained in care; interventions and education for case managers to implement	Retention in care outcomes; viral suppression outcomes; clients served by targeted medical case management	Funding limitations; lack of qualified personnel; data collection and systems challenges; confidentiality concerns; low interest and engagement among targeted populations

<p>Activity 3: Explore the implementation of peer advocacy programs to support engagement in care and treatment adherence</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	PLWH	Supporting organizations; CBOs, ASOs, and PLWH	Ongoing	Evidence of successful peer programs in other states and for other conditions; buy-in of supporting organizations; buy-in of PLWH; PLWH who will serve as champions in the peer advocacy programming; training and education	Implementation of peer advocacy programs	Provider and organizational buy-in; HIPAA regulations; competent peer educators; appropriate resources to support programming
<p>Activity 4: Explore app and/or online-based treatment adherence support interventions</p> <ul style="list-style-type: none"> • Viral Suppression 	PLWH	Supporting organizations, CBOs, ASOs, etc.	Ongoing	ISDH; all Ryan White parts; review successful implementation in other jurisdictions and for other conditions; technology	Piloting of option(s); implementation of app and/or online-based treatment adherence interventions; if implemented, viral suppression rates	Client access to tech resources; competency of potential users; cost and funding restrictions; legal and privacy concerns

Goal 3: Reducing HIV-related disparities and health inequities

Objective 1: Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: MSM, African American/Black populations, people who inject drugs, and young adults (ages 20-29) by 2021.

Strategy 1: Reduce HIV-related disparities in communities at high risk for HIV infection

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
<p>Activity 1: Increase access to HIV testing, care and treatment</p> <ul style="list-style-type: none"> • Diagnosed, Linkage to Care, Retained in Care, ART Use, Viral Suppression 	Populations experiencing HIV-related disparities	ISDH; all Ryan White parts; all HIV prevention and care organizations	Ongoing	Provider buy-in; funding from relevant sources; capacity building and training for providers; HIV prevention, care, and treatment recommendations; staff time	Increased testing among priority populations; increased care and treatment measures among priority populations	Limited financial resources; HIV-related stigma; lack of providers and time; lack of community engagement

Activity 2: Increase access to supportive care services <ul style="list-style-type: none"> Retained in Care 	Populations experiencing HIV-related disparities	ISDH; RWSP; disease intervention specialists (DIS); HIV care sites and providers	Ongoing	Provider buy-in; funding from relevant sources; capacity building and training for providers; HIV prevention, care, and treatment recommendations; staff time	Increased access to and utilization of supportive care services among priority populations	Limited resources; HIV-related stigma; lack of providers and time; lack of community and consumer engagement; consumer-level barriers (i.e., transportation)
Activity 3: Increase access to, uptake of, and adherence to ART <ul style="list-style-type: none"> ART Use, Viral Suppression 	Populations experiencing HIV-related disparities	ISDH; all Ryan White parts; pharmacies; medical providers; other HIV prevention and care providers	Ongoing	Funding to support ART usage; adherence interventions; seamless linkage processes; regular re-engagement in care efforts	Increased access to, uptake of, and adherence to ART among priority populations living with HIV; retention in care outcomes; viral suppression outcomes	Issues with insurance; mail order restrictions; inability to pay co-pays; competency of providers; disengaged consumers; consumer denial
Activity 4: Increase education, access, and adherence to PrEP and PEP	Populations experiencing HIV-related disparities	Existing and potential PrEP and PEP prescribers; pharmacists	By 2018 and ongoing	Funding options to support PrEP and PEP usage; client-level educational materials; PrEP and PEP providers; PrEP adherence support	Increased education, access, and adherence to PrEP and PEP among high-risk HIV-negative priority populations	Issues with insurance; mail order restrictions; inability to pay copays; competency of providers; disengaged consumers; consumer denial
Strategy 2: Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Continue to prioritize and fund social supportive services such as housing and emergency utilities <ul style="list-style-type: none"> Retained in Care, Viral Suppression 	Populations experiencing HIV-related disparities	ISDH; Ryan White Part A; CBOs, ASOs, and medical providers; other gov't agencies	Ongoing	Gov't assisted housing options; funding; collaborations with other housing and utilities assistance entities	Social supportive service utilization among priority populations	Limited funding and housing options; income restrictions; community and agency buy-in; lack of collaboration between housing assistance entities; competing priorities

<p>Activity 2: Increase enrollment in job training and continuing education programs</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	Populations experiencing HIV-related disparities	ISDH; Ryan White Part A; CBOs, ASOs, and medical providers; other gov't agencies; other education and/or employment assistance programs	Ongoing	Funding; trained education and employment specialists; GED courses and tutoring services; business attire support; resume/interview prep; development of peer employment programs for funded agencies	% of education and/or employment needs met among priority populations	Limited and restricted funding; lack of consumer interest; limited specialists to meet needs; community and agency buy-in; lack of collaboration among agencies and other education/employment assistance programs
<p>Activity 3: Scale up effective, evidence-based programs that address social determinants of health among high-priority populations</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	Populations experiencing HIV-related disparities	ISDH; Ryan White Part A & C; CBOs, ASOs, and medical providers; other gov't agencies	Ongoing	Expanded collaborations with organizations to address social determinants of health; funding; greater capacity to address social determinants of health via funded agencies	Increased efforts to improve social determinants of health among priority populations	Limited and restricted funding; limited organizations for partnerships in rural areas
Strategy 3: Reduce stigma and eliminate discrimination associated with HIV status						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Support policies that would prohibit discrimination, criminalization, and intimidation on the basis of sexual preference and HIV status	All Indiana citizens, especially priority populations	All Ryan White Parts; ISDH; all HIV prevention and care organizations	Ongoing	Political support; lobbyists; health foundations; policy and legislation writers	Number of modified laws/policies; number of proposed law/policy modifications	Rejection of proposed law/policy modifications; difficulty implementing change; cumbersome processes
Activity 2: Launch evidence-based and culturally competent educational programs to combat HIV-related stigma	All Indiana citizens	ISDH; all Ryan White parts; HIV prevention and care organizations	Ongoing	Funding (any relevant source), capacity building and training, strategies to accurately measure effectiveness of specific campaigns	Number of educational programs launched; number of organizations working to specifically address HIV-related stigma; increase in community engagement with HIV prevention and care services.	Insurmountable stigma in communities; lack of community engagement; disengaged providers; lack of capacity for implementing programming

Activity 3: Support education and training for HIV prevention and care providers to facilitate culturally competent and sensitive services for priority populations <ul style="list-style-type: none"> • Retained in Care 	Current and potential HIV prevention and care providers	ISDH Prevention, all Ryan White parts, MATEC	Annually and ongoing	Updated training and educational materials; training staff; funding for training and capacity building; agency/provider engagement	Number of individuals trained annually; number of trainings conducted	Inconsistency in curricula; difficulty determining who should receive training and from who; limited funding
Objective 2: Increase viral suppression to at least 80% among African American/Black populations, young adults (ages 20-29), and people who inject drugs by 2021.						
Strategy 1: Implement a variety of strategies to improve viral suppression rates among African American/Black populations living with HIV						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Activity 1: Ensure providers are educated and capable of meeting the specific needs of African American/Black PLWH <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	HIV prevention and care providers	ISDH; Ryan White parts; MATEC	Annually and ongoing	Educational and training materials focused on African American/Black PLWH; community organizations serving African American/Black populations; data on HIV and African American/Black populations in Indiana; CDC and HRSA resources	Increase in viral suppression; reduced community viral load; increase in retention in care; number of providers educated/trained; number of trainings provided	Provider buy-in; limited resources to support appropriate training and education; limited cultural competency among providers
Activity 2: Explore and implement options for supporting the health and insurance literacy of African American/Black PLWH <ul style="list-style-type: none"> • Retained in Care 	African American/Black PLWH	HIV-related case managers; medical care providers; insurance navigation specialists	Ongoing	Health and insurance literacy content; culturally competent providers; existing interventions to improve health literacy among African American/Black populations	Development of health literacy and insurance literacy educational materials; implementation of health and insurance literacy interventions for African American/Black individuals; increased health and insurance literacy among African American/Black populations living with HIV	Limited resources; limited engagement with African American/Black populations living with HIV; difficulty reaching people with greatest health and insurance literacy needs

<p>Activity 3: Expand and implement treatment adherence interventions targeted to African American/Black PLWH</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	African American/Black PLWH	ISDH HIV Prevention; CBOs, ASOs, and other prevention and care providers; pharmacies; peers; SEPs; case managers	By 2019 and ongoing	Evidence-based interventions for supporting treatment adherence; funding and staff for implementation; engagement of medical care, pharmacy, and case mgmt providers as potential facilitators	Number of African American/Black PLWH engaged via interventions; rates of viral load suppression; improvements in viral load among PLWH engaged in interventions	Limited funding, staff, and staff time; disinterest among target population; difficulty achieving viral suppression; difficulty monitoring viral load changes associated with intervention participation
Strategy 2: Implement a variety of strategies to improve viral suppression rates among young adults (ages 20-29) living with HIV						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
<p>Activity 1: Ensure providers are educated and capable of meeting the specific needs of young adults living with HIV</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	HIV prevention and care providers; pediatricians	ISDH; Ryan White parts; MATEC	Annually and ongoing	Educational and training materials focused on young adults with HIV; youth-focused community organizations; data on HIV and young adults in Indiana; CDC and HRSA materials	Increase in viral suppression; reduced community viral load; increase in retention in care; number of providers educated/trained on youth and HIV topics; number of trainings provided	Provider buy-in; limited HIV providers specifically serving young adults; denial of HIV among youth as a state concern; limited data relating to HIV among young adults in IN
<p>Activity 2: Utilize young adult-friendly strategies to encourage engagement in medical care and treatment adherence (i.e., social media, texting, peer programs)</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	Young adults living with HIV	HIV prevention and care providers; CBOs and ASOs; other community partners working with young adults	Ongoing	Social media presence; capacity to text and use other technological methods for communicating; peer engagement; young adult-focused providers	Implementation of young adult-friendly strategies; number of young adults living with HIV engaged via these strategies; rates of young adults engaged and retained in HIV medical care; treatment adherence and viral suppression	Lack of technological capacity; limited staff time; limited young adult-focused prevention and care providers; limited funding

<p>Activity 3: Explore and implement options for supporting the health and insurance literacy of young adults living with HIV</p> <ul style="list-style-type: none"> • Retained in Care 	Young adults living with HIV	HIV-related case managers; medical care providers; insurance navigation specialists	Ongoing	Age-appropriate health and insurance literacy content; providers experienced in young adult work; interventions to improve health literacy among young adults; use of social media and other technology to address health literacy topics	Development of young adult-focused health literacy materials; implementation of health literacy interventions for young adults; increased health and insurance literacy among young adults living with HIV	Limited resources; lack of engagement with young adults living with HIV; difficulty reaching young adults with greatest needs
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Strategy 3: Implement a variety of strategies to improve viral suppression rates among people living with HIV who inject drugs

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
<p>Activity 1: Ensure providers are educated and capable of meeting the specific needs of people who inject drugs</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	HIV prevention and care providers	ISDH; Ryan White parts; MATEC; other gov't agencies	Annually and ongoing	Educational and training materials focused on people with HIV who inject drugs; data on HIV and injection drug use in Indiana; CDC and HRSA materials	Increase in viral suppression; reduced community viral load; increase in retention in care; number of providers educated/trained on injection drug use and HIV topics; number of trainings provided	Provider buy-in; limited provider expertise on injection drug use and the needs of people who inject
<p>Activity 2: Increase access to drug treatment options, including medication assisted therapies, inpatient, and outpatient treatment</p> <ul style="list-style-type: none"> • Retained in Care, Viral Suppression 	People living with HIV who inject drugs	ISDH; all Ryan White parts; DMHA; other organizations focusing on substance use	Ongoing	Funding to support substance use treatment; increase of drug treatment providers; reduction in wait times for substance users seeking treatment; incentives for HIV care providers to incorporate drug treatment into their practice; education on HIV for drug treatment providers	Number of people living with HIV who inject drugs that access drug treatment; number of drug treatment options in the state; reduction of wait time for substance users seeking treatment	Limited and restricted resources; stigma; difficulty reducing treatment waits

Activity 3: Engage SEPs in providing treatment adherence education and interventions <ul style="list-style-type: none"> • Retained in Care, • Viral Suppression 	People living with HIV who inject drugs; SEPs	ISDH HIV Prevention; MATEC; SEPs; county officials	By 2018 and ongoing	Evidence-based interventions for implementation via SEPs; trained SEP staff; educational materials for SEPs	Number of SEPs providing treatment adherence education and interventions; number of SEP staff trained in HIV treatment adherence	Limited SEP staff time; limited existing SEPs and SEP participants; SEP-related stigma; confidentiality issues relating to SEP utilization and HIV status of participants; potential discontinuation of SEPs
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Goal 4: Achieving a more coordinated response to the HIV epidemic

Objective 1: Increase the coordination and integration of HIV prevention and care services across programs and agencies through 2021.

Strategy 1: Increase the number of patient-centered medical homes that provide bundled medical and supportive care services

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Identify existing medical homes throughout the state	Medical home providers throughout Indiana	ISDH; all Ryan White parts	By 2017 and annually, as needed	Financial and Human Resources Inventory; other statewide HIV care provider resource guides; online resources	Comprehensive guide and/or map outlining all medical homes throughout the state	Obtaining a comprehensive list of medical home providers; difficulty defining medical homes
Evaluate and explore existing patient-centered medical homes to identify best practices and strategies for expanding/adding medical homes	Existing and future patient-centered medical homes throughout Indiana	ISDH; all Ryan White parts	By 2019	Provider buy-in; existing medical homes to coach/guide new medical homes; human, fiscal, and information resources; feasibility study to determine the need and best locations for new medical homes	Number of medical homes throughout the state; increase in the capacity of existing medical homes	Lack of physical space to expand; limited human, fiscal, and informational resources; lack of demand for medical homes in low-incidence areas; competition for patients and resources among existing or newly formed medical homes; lack of capacity to successfully operate a medical home in rural areas

Explore additional funding to support the expansion of patient-centered medical homes	Medical homes throughout Indiana	ISDH; all Ryan White parts; existing medical homes	By 2017 and ongoing	Unrestricted funding; creative use of new and existing funding; local and national health foundations; private funders; models from other states	Increase in funding options to support medical home expansion	Funding priorities may not allow for increase in patient-centered medical homes; lack of funding opportunities; limited human, fiscal, and informational resources; differences in funding priorities
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Strategy 2: Enhance data integration and sharing across all Ryan White-funded providers, STD/HIV testing, and communicable disease programs

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Develop guidelines to support data sharing between funded entities and providers who share clients	Ryan White and State funded care coordination sites, ASOs, and HIV clinical agencies	ISDH; all Ryan White parts; administrators and directors of care coordination, ASOs, and clinical agencies	By 2017	Buy- in from providers; data sharing agreements; memorandums of understanding; IT support	Completed guidelines	Agencies may not want to integrate services due to fees for service; limited fiscal, human, and informational technology resources; fear of change; confidentiality and HIPAA concerns
Establish standardized data collection processes and reports to minimize double and triple data entry and processing	Ryan White and State funded care coordination sites, ASOs, and HIV clinical agencies	ISDH; all Ryan White parts; administrators and directors of care coordination, ASOs, and clinical agencies	By 2020	Buy- in from providers; HRSA and CDC guidance; data collection manual or guidelines for all relevant parties	Development and implementation of standardized data collection processes; reporting mechanisms	Inability to integrate data systems; difficulty establishing consensus on data collection guidelines; inconsistent data entry; poor data quality
Data to Care???						

Strategy 3: Adopt creative models of care to expand the service delivery capacity of existing medical and social service agencies						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Expand capacity of existing service providers and increase productivity of service delivery by adding paraprofessionals such as community health workers and peer educators to the healthcare team	Existing service providers	ISDH; Ryan White parts; MATEC; existing service providers	Begin by 2018, continue as needed	Qualified peer educators and community health workers; metrics, productivity, and efficiency measures; training and development resources; MATEC	Number of people served; patient contact hours; number of new healthcare team members	Defining productivity and efficiency measures; buy-in from existing staff; territorial/turf issues; funding for paraprofessionals; limited interest among paraprofessionals and peers
Explore opportunities for co-locating HIV prevention and care services through “minute-clinic” models at pharmacies in geographic areas with high HIV prevalence	All citizens, including PLWH, in high-prevalence geographic areas	ISDH; Ryan White parts; pharmacies in high-prevalence areas; community partners	By 2018	Existing models implemented in other states; engaged and committed pharmacies and pharmacists; program marketing materials; data sharing agreements and systems; MATEC; training and educational materials for staff; data on client acceptability of accessing HIV services via pharmacies	Number of pharmacies engaged to provide HIV services; if implemented, number of clients served; number of tests conducted	Buy-in from providers; lack of interest among pharmacies; contract issues with insurance companies; confidentiality and HIPAA concerns; potential to further fragment HIV care and service provision
Incorporate use of technology, such as telemedicine, to increase accessibility and delivery of primary HIV care to clients living in outlying/rural counties and to clients who are unable to travel to distant HIV care sites	PLWH who are retained in care and are virally suppressed, esp. those with accessibility to care concerns	ISDH; all Ryan White parts; existing HIV service providers	Ongoing	IT support; criteria for telemedicine-eligible patients; technology equipment; funding to support service delivery; training for healthcare providers; client-level data on acceptability of tech-based service delivery	Number of patients served through telemedicine or other tech-based services	Generational differences and preferences regarding technology; discomfort with technology; need for in-person contact; funding for equipment, training, and providers; limited access to technology among clients with greatest needs

Objective 2: Maintain a comprehensive integrated statewide plan for HIV prevention and care by updating the plan on an annual basis through 2021.

Strategy 1: Continue to develop and utilize relevant data sources for effective planning

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Adopt standard data definitions to guide data collection, reporting, and epidemiology reports	ISDH; all Ryan White parts	ISDH; all Ryan White parts	Initially by 2017, review annually	HRSA and CDC recommendations	Development and implementation of standard data definitions	Difficulty implementing changes with collecting, reporting, and analyzing measures; data system issues
Use epidemiological and needs assessment data to update and evaluate goals	ISDH; all Ryan White parts	ISDH; all Ryan White parts; planning bodies; plan monitoring work group	Annually	State epi data; TGA epi data; needs assessment data; epidemiology staff members	Utilization of epi and needs assessment data in planning processes	Difficulty changing existing processes and procedures; diffusion of responsibility; data lags
Maintain an accurate statewide human and fiscal resources inventory	ISDH; all Ryan White parts	ISDH; all Ryan White parts	Update every 2 years	Existing resource inventories; online resources; provider input	Development and updating of a human and fiscal resources inventory	Accounting for ongoing changes among listed resources; large magnitude of information to track and update
Conduct a collaborative needs assessment to support planning efforts	ISDH; all Ryan White parts	ISDH; all Ryan White parts	Initially by 2019, and every 3 years	MATEC; planning bodies; previous needs assessment data; reference materials from other states	Completion of a collaborative needs assessment	Collaboration between planning bodies; capacity to conduct needs assessments; research exhaustion among clients; length of needs assessments accounting for HIV prevention and care

Strategy 2: Maximize community member and stakeholder engagement in the planning process

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Hold statewide all-parts meeting to increase collaboration and communication	Community Members and Stakeholders	ISDH, Ryan White, ASO	At least once annually	ISDH, Ryan White	Completion of annual meeting	Lack of participation, funding, Physical barriers for collaboration, Ability to coordinate a collaboration meeting
Integrate HIV Prevention and HIV Services planning bodies at the state level	HIV Prevention Community Planning Group; Comprehensive HIV Services Planning and Advisory Council	ISDH	By 2018	Reference models from other states; support from HRSA, CDC, and NASTAD; development of integrated bylaws and membership structure	Development and implementation of an integrated state-level planning body	Difficulty changing existing processes and procedures; diffusion of responsibility; territorialism

Implement creative strategies to increase consumer and community member involvement in planning	All Indiana Citizens	ISDH, Ryan White, CBO, ASO	December 2017, Updated annually	Planning Bodies, Advisory Counsels	Increase Consumers and community member involvement	Community buy-in, Health in Consumers (baby boomers)
Establish and maintain key partnerships to support HIV planning processes	CBO,ASO, ISDH, Ryan White	CBO,ASO, ISDH, Ryan White	Ongoing through 2021	Integrated meeting with planning bodies, CDC, HERSA	Participation of ASO, CBO Increase new partnerships	Some agencies are being silo. Lack of collaborations. Lack of communication between ASO, CBO,
Strategy 3						
Ensure regular plan development and maintenance processes						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Establish guidelines for responsibilities and responsible parties for ongoing maintenance of the plan	All Parts, and planning bodies	All Parts and Planning Bodies	By submission 1/1/2017	All Parts and Planning Bodies, Work Groups	Completion of 1/1/2017	Keeping people engage. "HARD"
Implement appropriate monitoring and improvement strategies for plan updates and progress tracking	All Parts and Planning Bodies	All Parts and Planning Bodies	Ongoing through 2021	Epidemiology, needs assessment, all parts and planning bodies	Establish goals	Strategies not working, Resources of the staff to make and to monitor and to adjust, Changes in the virus.

Goal 5: Ensuring continued financial and other resources to support HIV service delivery

Objective 1: Maintain stable and diverse funding streams to support HIV prevention and care service delivery ongoing through 2021						
Strategy 1: At a minimum, strive to maintain existing funding to support HIV prevention and care efforts across Indiana						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Encourage all directly funded entities to effectively budget and spend down funds to demonstrate need	All Ryan White parts; ISDH; all other directly funded agencies	All Ryan White parts; ISDH; all other directly funded agencies	Annually, through 2021	Meeting grant requirements and applying as appropriate; budgeting strategies; ongoing monitoring and improvement on budgeting and spending of resources; use of Ryan White planning council for guidance and support	Amount of grant funds spent; budgeting and budget revisions as needed; ongoing monitoring of consumers in care	Grant requirements for spending and allocations; reductions or other changes in funding streams; changes in requirements or regulations; difficulty spending all funding; challenges with consumers

For Ryan White parts, request a waiver to alleviate the 75/25 spending restrictions	All Ryan White parts	All Ryan White parts; FSSA; Department of Insurance; Ryan White Planning Council	Annually, through 2021, or until HRSA requirements change	HRSA; epi reports and planning council reports to justify need; appropriate steps taken by each Ryan White program director	Request for waiver; receipt of waiver	HRSA and Ryan White grant requirements; lack of data-based justification for the waiver; decreased usage of resources as related to the waiver; changes in political climate; overall changes with Ryan White programming
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Strategy 2: Explore additional funding opportunities to support service delivery

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Establish and update a grants database to increase knowledge of competitive and unrestricted grant opportunities	All grant-seeking entities providing or guiding services relevant to HIV prevention and care	Ryan White Part A and ISDH; possible development of a specialized committee to seek out and share grant opportunities with planning bodies and program areas	Ongoing, through 2021	Grants specialists and program directors; strategy for developing and updating a grants database	Initial development of a grants database or reference system; ongoing maintenance of the system; utilization of the resource	Difficulty with effective dissemination of information; limited and restricted resources; promoting collaborative community attitudes toward grant opportunity seeking; siloing
Apply for unrestricted dollars to support programming and resources that are not currently funded through existing grants	Agencies who offer specialized services; potential providers of specialized services	Agencies and organizations currently or potentially providing specialized services (i.e., substance abuse services, mental health care, etc.)	Ongoing, through 2021	Funding opportunities; avenues for learning about funding opportunities, esp. those not specifically related to HIV; assess what current organizations use to fund specialized services; skilled grant writers	Increase in the use of unrestricted dollars to support specialized service delivery, esp. for PLWHA; increase in the provision of specialized services	Limited, restricted, and highly competitive resources; lack of knowledge of funding; organizations with limited grant seeking and writing capacity

Strategy 3: Develop and maintain partnerships with other funded entities whose resources can help meet needs associated with HIV prevention and care

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Collaborate with organizations funded to meet public health needs associated with mental health	Organizations and groups specifically funded to meet public health needs associated with mental health	Ryan White staff; ISDH staff	Ongoing, through 2021	Organizations and groups to build collaborations with; ongoing engagement with mental health stakeholders	Increase in involvement with mental health-focused entities, boards, and councils	Limited staff time; competing priorities; difficulty establishing effective and ongoing relationships with mental health-focused entities; entities who are reluctant to engage HIV-related priorities
Collaborate with organizations funded to meet public health needs associated with substance use	Organizations and groups specifically funded to meet public health needs associated with substance use	Ryan White staff; ISDH staff	Ongoing, through 2021	Organizations and groups to build collaborations with; ongoing engagement with substance use stakeholders	Increase in involvement with substance use-focused entities, boards, and councils	Limited staff time; competing priorities; difficulty establishing effective and ongoing relationships with substance use-focused entities; entities who are reluctant to engage HIV-related priorities

Objective 2: Increase the fiscal health and stability of agencies providing HIV prevention and care services ongoing through 2021

Strategy 1: Improve the stability of existing HIV prevention and care agencies

Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Increase the financial stability of agencies to support adequate wages and reduce staff turnover	Agencies funded to provide HIV prevention and care services	Ryan White parts; ISDH	Annually and ongoing	Funding; education for agencies, providers, and funders; establishment of expectations between Ryan White and ISDH on defining competitive wages for service provision; explore reference resources to determine competitive wages for similar work in similar geographic locations	Reduce rates of staff turnover; number of retained staff and length of employment; adjustments in wages for service providers	Differences in costs as related to geographic location, staff qualifications, and service provision; difficulty agreeing on a definition for competitive wages; difficulty paying staff competitively as compared to private sector positions; unpredictability of funding and potential funding changes

Establish statewide recommendations for service priority setting and resource allocation at the agency level	Agencies funded to provide HIV prevention and care services	Ryan White parts; ISDH; planning bodies	Annually, through 2021	Ryan White and ISDH planning bodies;	Completion of collaborative priorities and recommendations for resource allocation; data-based priority setting for recommendations	Developing meaningful recommendations for agencies of different sizes and priorities; difficulty with priority setting between Ryan White and ISDH
Strategy 2: Improve capacity development efforts for new and small organizations to provide HIV prevention and care services						
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Explore collaborative business models to support the fiscal health of small and start-up agencies	Small and start-up agencies; new providers	ISDH and Ryan White	Ongoing through 2021	Statewide resource inventory; funding; legal support; professional contractors to assist with initial establishment; utilization and needs assessment data	Increase in new, funded agencies; financial stability of small and start-up agencies	Difficulty defining financial stability clearly; business illiteracy; challenges in meeting funding expectations; availability of multiple funding streams
Develop agency partnerships and mentorships for new and small HIV prevention and care service providers	New and small HIV prevention and care providers; established and effective agencies and providers to serve as mentors	ISDH and Ryan White; MATEC	By 2018; ongoing through 2021	Well-performing agencies; support for business management mentorship; accessing existing mentorship programs; use of technology to support statewide mentoring	Stabilization and growth of new and small agencies; number of partnerships and mentorships; long-term improvements in the care continuum	Competition; fear of being absorbed by larger agencies; technological barriers; cost and lost time; limited staff time; establishing stability and consistency among partners

Strategy 3	Ensure appropriate and effective use of financial and other resources					
Activities/Interventions	Targeted Populations	Responsible Parties	Timeframe	Resources	Data Indicator	Anticipated Challenges/Barriers
Ensure that Ryan White is the payer of last resort	All Ryan White funded entities	Ryan White program	Ongoing, as clients receive services	Processes to ensure ongoing program eligibility with clients; reliable referral processes; cross-checks with insurers to monitor billing and appropriate payment	Use of data reports for eligibility and denials; reconciliation reports; audits and measure of errors on unjustifiable payments	Burdensome referral process; difficulty engaging all providers in checking for client eligibility; recertifications
Explore funding options to support syringe exchange programming, including the possible use of CDC HIV Prevention funding	Counties who are or will provide syringe exchange programming	ISDH	2017 and ongoing	Unrestricted funding; explore options for SEPs to bill for testing to create revenue; creative use of new and existing funding; local and national health foundations; private funders; models from other states	Securing unrestricted funding to support SEPs; number of entities proving SEP	State laws and regulations; difficulty finding unrestricted funds; limited state-level options for funding; political environment; general public opinion of SEP and related stigma
Develop processes to encourage collaborative budgeting and financial management	ISDH; Ryan White parts	ISDH; Ryan White parts; planning body	Begin 2017; continue annually	Cooperation between existing bodies; establishment and maintenance of an ongoing process; willingness to be transparent with budgeting and financial management	Development of a final financial plan collaboratively developed between ISDH and Ryan White	Lack of transparency; buy in from agencies; difficulty establishing consistency

B. Collaborations, Partnerships and Stakeholder Involvement

Describe the specific contributions of stakeholders and key partners to the development of the plan.

The development of the Indiana Integrated Prevention and Care Plan was accomplished in partnership with several important stakeholder and key partners. Their input, assessment and/or their individual representation were integral to the development of the Indiana Plan. Planning utilized cross-part collaborative partnership between the Ryan White Parts A, C, MAI, the ISDH's Part B and HIV/STD prevention programs, MATEC, key stakeholders, medical and support services providers, and a variety other community leaders. The community key stakeholders included membership of the three Planning Bodies, Statewide AIDS Service Organizations, Statewide HIV Community Based Organizations, agencies serving minority and underserved populations throughout the state, local and statewide philanthropic organizations, and local, state and federally funded governmental agencies and grantees. The Plan also received input on the Plan or assessment of the Plan from representatives of the ISDH Care Coordination System and of the ISDH CDC- funded prevention programs. Additional input was solicited for all sub-recipients of the Part A, B, MAI and CDC funded agencies. The most significant impact on the development of the Plan can from PWLH and is discussed in the section following. Together, these entities addressed areas of unmet need, identify hard to reach populations at risk for HIV infection, and helped to develop strategies, activities and programs to increase HIV testing, early detection, and entry into and retention in care to develop goals and objectives that will improve all elements contained in the Care Continuum and to satisfy the goals and objective of the National HIV/AIDS Strategy. These entities and/or individuals helped to formulate strategies to target high risk populations at key entry points of entry and to support entry to and access to care, retention in care and the reduction of individual, community and statewide viral loads.

In the areas of prevention these key stake holders and community partners were essential in providing input into the development of goals/objectives and activities designed to: 1) increase HIV targeted testing and counseling to high risk populations and in rural areas of the state; 2) referral to services for those presenting positive or that are positive and unaware of their HIV states; 3) linkage to and retention in care for those presenting positive; and 4) health education and literacy training to enable clients to navigate the HIV system of care. The Planning Bodies were essential in gaining input from the communities they represented and bringing them to the attention of the Steering Committee and /or individual work group. Some of the items brought forward were: 1) the need to disseminating up-to-date HIV resource guides containing HIV information and the importance of early diagnosis, and access to services for providers and PLWH; 2) expanding access to rapid testing; 3) continuing collaboration with DIS to locate individuals who were not post-test counseled or did not return for their test results; 4) supporting partner notification services, follow-up, and referral to care; and 5) using funded outreach services to locate and refer to care individuals who test positive. The input from these groups and/or individuals also included specific recommendations regarding: 1) universal screening through inner city hospital EDs and agencies providing services tailored to at-risk populations; 2) co-location and utilization of DIS to assist in locating and notifying individuals who are unaware of their positive status and facilitating with partner service notification; 3) increasing collaboration with CBOs and prevention agencies providing rapid testing; 4) increasing the

number of agencies using peer based outreach to encourage HIV testing for those unaware and; 5) assisting in the location of those who present positive and do not return for results and to assist in linking those who are positive into care; 7) increasing CTR programs utilized the latest HIV testing protocol and to continue to partner with STD Clinics to provide direct partner service notification, partner testing, and linkage to care and; 8) increasing access to non-traditional testing sites at various social service agencies. All of these recommendations and incorporated in the goals and objectives section of this Plan.

The key partners/stakeholders associated with the provision of care services were also instrumental in contributing to the development of the Integrated Plan, including the membership of the three Planning Bodies. One of the major foci regarding the development of the Plan was to seek as much community input as possible. These collaborations were essential in addressing the following issues as they relate to the NHAS : 1) early disease detection for those who are HIV-positive but not yet aware of their status; 2) access to care for those who are HIV-positive but are not engaged in care and; 3) prevention education for those who are HIV-negative. These recommendations helped to develop a comprehensive plan that seeks to improve the continuum of care in Indiana through a system that efficiently identifies, informs, refers, and links unaware HIV-positive persons to care; that seeks to retain status-aware HIV-positive persons in care; that refers HIV-negative persons to the appropriate support services to help them remain HIV-negative; and provides the highest caliber of HIV medical and support services. These collaborations with partner, key stakeholders, medical and supportive service providers, and other community leaders proved invaluable in the creation of the Indiana Plan.

These groups, especially the three Planning Bodies wanted to ensure that funding was utilized in an efficient and effective manner to ensure that services do not overlap and that funds are never supplanted, all of which are consistent with the National HIV/AIDS Strategy and HRSA's goal to decrease HIV-related health disparities among vulnerable populations and historically underserved communities by increasing access to quality services and that funding would be sued to expand services throughout Indiana. Each of these recommendations is reflected in the goals and objectives of this plan.

Medical and service representatives also wanted to ensure access to equitable HIV medical care. The entities representing the rural areas of Indiana provided data and information as to the lack of expertise of many of the rural health providers regarding the care of PLWH. They wanted to seek an expansion of training opportunities for Primary Care Physicians, FQHC staff and rural medical professionals.

Those entities representing Case Management services indicated a need for increased resources and training for staff, including increasing wages in order to attract and maintain a qualified and viable work force. PLWH and members of the Planning Bodies also wanted to increase the numbers and expertise of this professional base. They also realized the importance of the Case Management system as it provides the gateway to services for PLWH. These programs include Medicare, Medicaid, the Healthy Indiana Plan, and the ISDH HIV Medical Services Program which includes the health insurance assistance component. The latter works in conjunction with private insurance providers as well as those operating within the Health Insurance Marketplace made possible by the passage of the Affordable Care Act.

Additional issues brought forward by the community partners included addressing the needs of emerging communities, communities of color, rural communities, status of-unaware individuals, and the unmet need population. They also provide input on the need to create programs that alleviate common barriers such as lack of transportation, unstable housing, and emergency financial needs.

Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum.

There are additional stakeholders/partners that need to be more active in this Plan's implementation and continuation in order to improve the outcomes along the HIV Care Continuum. These include HOPWA representation, local and state political leaders, representatives from Rural Health Care Agencies/Physicians, members of the religious community, educational representation, PLWH that are not currently out of care, increased representation from the Indiana Department of Corrections and local law enforcement.

Letters of Concurrence (See Attachment)

1. The Indiana State Department of Health:
Ryan White Part B (HRSA) and CDC Funding
2. The Marion County Public Health Department
Ryan White Part A, C and MAI
3. Chair and Co-Chair Comprehensive HIV Services Planning and Advisory Council
Ryan White Part B
4. Chair HIV Prevention Community Planning Group
Prevention Funding
5. Indianapolis TGA Ryan White Planning Council
Ryan White Parts A, C and MAI

C. People Living With HIV (PLWH) and Community Engagement

Describe how people involved in the developing the Integrated Plan are reflective of the epidemic in the jurisdiction

Throughout the development and writing of the Integrate Plan the Steering Committee and Federal recipients were committed to ensuring that PWLH were involved in all phases of the plan development and that participation in the creation of the plan was reflective and representative of the of those living with HIV, those impacted by HIV, and groups at high risk for HIV. The planning process included representation from a diverse cross section of race/ethnicities, genders, sexual orientations, and those individuals and agencies reflecting the experiences and expertise of those impacted by HIV in the jurisdiction, and geography. The Federal recipients and Steering Committee recognized the importance and essential role of PLWH, especially those who are consumers of services, if planning and implementing programs were to be successful. This process of inclusion was essential in the development of the strategies to enhance coordination, collaboration and maintain a seamless access to HIV prevention, care, and treatment. This inclusion helped to ensure that HIV prevention and care activities will be responsive to the needs of the jurisdiction being served by this Plan. To ensure reflectiveness PLWH the following occurred: 1) the membership of the individual workgroups;

2) the membership of the Steering Committee; 3) the membership of the CHSPAC; 4) the membership of the CPG and; 5) the membership of the Ryan White Part A Planning Council.

To demonstrate reflectiveness of those involved in the process the following is noted. The epidemiology of HIV disease in Indiana is explained in the initial section of this plan and indicates that the prevalence rate of HIV infection in Indiana is 79.7% male and 20.3% female; 36.8% black non-Hispanic; 50.50% white non-Hispanic; and 8.30% Hispanic. Regarding age: 20-29 (11.9%); 30-39 (18.5%); 40-49 (28.1%) and over 50 (40.4%). Overall membership participation in the development of the Plan is as follows: 49% of the participants were men (below the prevalence rate) and 51% women (above the prevalence rate); 32% were black non-Hispanic (slightly below the prevalence rate); 60% white non-Hispanic (above the prevalence rate); and 5% Hispanic with 0.006 representation of the Asian/Pacific Islander population; 26% of the participants represented the GLBTC and 0.12% individuals represented the injecting drug use population. Age is not a demographic that is collected by all participating groups but in a survey that was designated by the ISDH to membership for this process of the responses received 8.33% were between the ages of 20-29; 41.67% between the ages of 30-39; 25% between the ages of 40-49; 25% over the age of 50.¹⁷⁵

The diversity of the agencies represented by those in the planning and decision process include; Infectious Disease Clinics; Urban hospitals and emergency departments; care coordination, medical and non-medical case management providers, pharmacies and pharmacists; counseling, testing and referral programs; mental health providers, substance abuse providers, community based organizations including those serving minorities and communities of color; AIDS service organizations including those serving minority populations and communities of color; county and state health departments; philanthropic organizations; Medicaid, Schools of Dentistry, Federal Qualified Health Care Centers; Homeless Initiatives; and neighborhood health clinics.

Geographically almost all portions of the state were represented including representation from both rural and urban communities and populations. Those counties of the state most impacted by HIV were all represented. They are Marion, Vanderburgh, Lake, Allen, St. Joseph, and Clark. Also, there was representation from Scott County which experienced a significant HIV outbreak in 2015.

The following populations were represented by those directly involved in the development of this Plan: African American men (Heterosexual); African American women; African American MSM; Hispanic Men (Heterosexual); Hispanic Women; White non-Hispanic MSM; White non-Hispanic women; youth in communities of color and MSM, Asian Pacific Islanders; mental health consumers and providers; substance abuse consumers and providers; injection drug user and providers; those currently or formerly incarcerated; those historically underinsured and/or underserved, sex industry workers, foreign born immigrants and those undocumented.

Describe how the inclusion of PLWH contributed to the Plan Development

PLWH were involved at all stages of the Plan development, assumed leadership roles in the work groups, served on the Steering Committee and assisted with presenting to Planning Bodies for updates and obtaining letters of concurrence. Of specific note was that a PLWH was Co-chair of the Goals and Objective work group and was instrumental in keeping the group focused on the establishment of programmatic issues throughout the process. This Plan would not be as

comprehensive or client-centered without the input of PLWH at all phases of its development. PLWH provided both qualitative and quantitative data, life experiences regarding barriers to care, equitable access to service, and rationale as to why some PLWH do not access care or are retained in care. PLWH provided peer to peer interaction on what was needed, what was lacking, the identification of barriers to care, and how to improve the overall service delivery. These individuals also sought to simplify the process and to make the Plan understandable to those that will be receiving the services designated by and in this Plan.

PLWH were deliberate in utilizing data for decision making and to ensure “client voices” were heard in the anticipated funding decisions and in the establishment of goal and objectives. For example, during the planning PLWH considered data regarding persons unaware of their HIV status, EIIHA data, and barriers to testing for those historically underserved populations to establish prevention goals. Unmet and unaware data and barriers to services data was used to devise goals and objectives to increase early entry into care and retention in care. Data regarding the anticipated increase of new clients entering care, the continued impact of the ACA and the Healthy Indiana Plan, assisted in the formulation of goals and objectives to increase funding for non-medical case management and medical case management, outpatient ambulatory/primary medical care. PLWH serving on the work groups and those of the individual Planning Bodies invested time and energy in working through a multitude of data sources in order to make decisions based on data and not supposition; however, they also provided the human aspects of HIV and services that are needed to live a long and productive life.

Describe the methods used to engage communities, PLWH, those at risk of acquiring HIV and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.

PLWH and those representing communities at risk of acquiring HIV were involved from the beginning of this process. They were at the table at the initial meetings, invited to attend the trainings, invited to be part of the work groups and steering committee. Members of all three of the Planning Groups were given the task of reporting back to their individual communities about the Plan and its intent and purpose and to assist in the gathering of information and data that was presented to the appropriate work groups. Throughout the course of the year the Federal recipients and Planning Bodies participated in a variety of events to promote the individual and collective programming that is available throughout the jurisdiction.

In order to gather community data, especially from those living with HIV, Planning Body members and staff continually reached out to the community for input and soliciting PLWH to be members of their individual Councils. For example, In order to gain input from affected or infected communities and solicit membership in FY 2015 the Part A Planning Council partnered with and participated in 11 individual events designed for consumers or designed to reach populations that would benefit from HIV prevention and care services. Planning Council members who participated in the events encouraged individuals to sign up for additional information about programming, its importance and how to access, how to become a member and encouraged individuals to attend meetings even if they were not interested in membership at this time. Event participation allowed the members to provide information on availability of programming, the means to access services, a discussion of community needs represented by those in attendance, barriers to receiving service, and recommendations on how to improve the

jurisdictions continuum of care. Findings and outcomes of each of these sessions were summarized and presented to the work groups for consideration before the goals and objectives were finalized.

During the past grant year the Ryan White Program and members of its Council were represented at the National Black HIV/AIDS Awareness Day (February 7, 2015); Hamilton County Resource and Health Fair (April 3, 2015); National Week of Prayer for the Healing of AIDS (March, 2015); Indy Pride (June 13, 2015); Indiana Latino Expo (June 20, 2015); National HIV Testing Day (June 27, 2015); Indiana Black Expo Summer Celebration- IN-Shape Black and Minority Health Fair (July 16-19, 2015); Miss Grand Prix (July 19, 2015); and partnered with community agencies to participate in World AIDS Day (December 1, 2014). The PC will also participate in 2015 World AIDS Day activities. The PC collaborated with Brothers United (CBO for African Americans, MSM and transgender) for Indiana Pride of Color (July 17-18, 2015); Indiana AIDS Walk (September 26, 2015); and Grand Masquerade (Damien Center – October 17, 2015).

Members also conducted individual presentations on behalf of the program and the Plan at support groups and other community functions. During the past two years, the PC's Community Access Committee conducted client-centered meetings at agencies throughout the TGA with the goal to acquaint individuals with services, the PC, and how to become involved in the future of HIV planning in the State and TGA. The meetings are led by consumers, the Chair of the Consumer Access Committee, and RWSP staff, including the Director.

Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of needed resources.

Access to impacted communities is currently being accomplished by utilizing members of the three planning bodies, sub-recipients formal and informal networks that provide services to these communities, and PLWH peer to peer interactions. Additionally, for the purposes of this Plan the ISDH conducted a statewide needs assessment that targeted those both in care and not in care, those at high risk for HIV and those individual that are considered to be historically underserved.

Information obtained from the community processes assisted planning and decision making and emphasized the importance of this data regarding funding. For example, one outcome was to highly prioritize and increase funding to medical and non-medical case management, as these services are the gateway into care as well as being essential to keeping clients retained in care. Second, highly prioritizing and increasing funding for EIS and outreach to locate individuals that are HIV positive and unaware of their status. This will allow individuals to present to care at an earlier stage of disease to improve their overall health outcomes, reduce the community viral load, and assist in the reduction of HIV transmission. Third, maintaining access to quality and culturally appropriate medical care and pharmacy services.

SECTION III: MONITORING AND IMPROVEMENT

A. Implementation Progress

Monitoring the implementation of the Integrated Plan is critical for understanding which elements of the plan need to be modified or improved. This responsibility is shared by the respective Ryan White Program recipients and the Monitoring and Improvement Workgroup (MIW) that was established by the Integrated HIV Prevention and Care Plan Steering Committee in early 2016. The MIW is currently composed of representatives from Ryan White Part B, the state's HIV Prevention Community Planning Group (CPG) and Comprehensive HIV Services Planning and Advisory Council (CHSPAC), Parts A and C (collectively referred to as the Ryan White Services Program or RWSP), and the RWSP Planning Council. Beginning in 2017, the MIW membership will be defined as follows:

- The chair, a consumer representative, and one other member of CHSPAC;
- The chair, a consumer representative, and one other member of CPG;
- The chair, a consumer representative, and one other member of the RWSP Planning Council;
- A representative from Marion County Public Health Department (MCPHD); and
- A representative from the Indiana State Department of Health (ISDH).

Additionally, the demographics of the MI Workgroup will reflect those of the HIV epidemic in Indiana to the extent possible. From among the workgroup's membership, ISDH and MCPHD will each select one individual to serve as co-chairs. The MIW will be purposely structured to include an odd number of members to facilitate consensus decision-making. The group will continue to meet regularly throughout the five-year implementation period of the Integrated Plan. During the first year of implementation, it plans to meet at least once each quarter; twice yearly meetings may be considered in subsequent years.

Each quarterly meeting will address predetermined milestones, often related to standard reports and projects which are completed by the recipients at designated times throughout the year. The initial milestones that have identified for 2017 are listed below according to the quarter in which they are to be reviewed by the MIW.

- **First Quarter 2017.**
 - Status of "Initial Expectations" directives described below; and
 - Any reaction to emergent issues (e.g., a disease outbreak).
- **Second Quarter 2017.**
 - Revised state epidemiological data;
 - Revised Transitional Grant Area (TGA) epidemiological data;
 - Part A Viral Load Analysis report;
 - Unmet Need report for the RWSP;
 - Unmet Need report for Part B (including Viral Load Analysis);
 - Any reaction to emergent issues.

- **Third Quarter 2017.**
 - Quality Management report for the RWSP;
 - Quality Management report for Part B;
 - Special Populations Support Program Testing Site Visit report summary from ISDH;
 - Prevention Site Visit report summary from ISDH;
 - Care Coordination Site Visit report summary from ISDH;
 - RWSP Site Visit report summary; and
 - Any reaction to emergent issues.
- **Fourth Quarter 2017.**
 - Integrated Plan Objectives Progress report; and
 - Any reaction to emergent issues.

The MIW will review relevant materials to confirm the completion of the applicable milestones. Following the review each quarter, the workgroup will issue a brief report to a representative of one or more of the funded recipients, indicating if any sections of the current Integrated Plan could be impacted by the review's conclusions.

Many of the milestones listed above are self-explanatory the recipients and most planning body members. The "Initial Expectations" directives referenced under the first quarter refer to a set of steps that the MIW considered necessary to ensure the successful launch of the Integrated Plan. These steps included the following imperatives:

- Goals and objectives must be specific and measurable;
- Basic evaluation tools must be finalized and available;
- MCPHD and ISDH must have plans in place to ensure that future Requests for Proposals (RFPs) and contracts reflect the Integrated Plan;
- MCPHD and ISDH must indicate that funding is sustainable and sufficient to achieve current goals;
- MCPHD and ISDH must have plans to seek additional funds to expand and improve services in subsequent years;
- ISDH must have a plan to assess and update its current funding methodology for prevention services;
- MCPHD and ISDH must have plans in place (and preferably documented in future RFPs) to improve the performance of under-achieving programs;
- MCPHD and ISDH must have plans to adopt minimum score thresholds for RFP responses to help ensure the quality and capacity of providers.
- MCPHD and ISDH must have plans in place to expand the capacity of programs in areas of high-need (e.g., such programs may be encouraged or required to utilize a funding matrix similar to the one used for the Housing Continuum of Care to identify and seek other potential funding sources for programming).

The Integrated Plan Objectives Progress Report slated for the fourth quarter refers to the MIW's full review of the plan's goals and objectives. This review process is described in detail later in this Section.

Quarterly review results and any MI Workgroup comments will also be shared with the two planning bodies in the course of their regularly scheduled meetings. Feedback will be solicited

from each planning body in this context and will be used by the funded recipients to temper or support the comments provided by the MI Workgroup.

The Integrated Plan will be revised annually based in part on the quarterly feedback from the MI Workgroup related to the identified milestones. The annual Integrated Plan revisions will be finalized by the end of the first calendar quarter each year following the previous year's review process.

B. Goal Monitoring

An essential component of the monitoring process is the creation of a Progress Report by the MIW during the fourth quarter of each year of the project period. This report is the result of a comprehensive review of each goal and objective listed in the plan. The review will be informed by the documents and reports received during the previous three quarters of the year and will be completed with subject matter experts, including RWSP and Part B representatives. Each objective will be marked as Not Achieved, Achieved, or Exceeded, and an official report will be issued with results and recommendations.

The MIW's progress assessment will be based on outcomes documented for the individual objectives identified for each goal. Specific numerators and denominators for each outcome indicator have been developed and are or will be provided to contracted providers to ensure consistency in methodology. Performance data will be obtained from CAREWare and other electronic systems used by the contracted providers. This data will then be aggregated by the recipients for use in reports and for the purposes of the MIW's progress assessment.

Once the assessment is completed, the MI Workgroup will issue to the Integrated Plan Contact Person its Progress Report which includes recommendations for service enhancements and goal revisions. The results and recommendations will be shared with the respective planning bodies and used by the recipients to adjust service delivery as necessary.

C. Assessment of Health Outcomes

The RWSP and Part B recipients each prepare annual epidemiological profiles, Unmet Need reports, Community Viral Load Analysis summaries, and Clinical Quality Management (CQM) reports. Each recipient maintains its own protocols for these reports, details of which are not included herein; however, the schedule for these activities will be synchronized in 2017, and the resulting documents will be forwarded to the MIW for review and feedback as noted previously.

Client-Level Data

The assessment of HIV health outcomes is based primarily on client-level data. RWSP sub-recipients, as a condition of award, record service provision data at the client-level. These data are managed using CAREWare and RISE; however, they are often merged with data from eHARS in order to collect information not captured by these databases (i.e., surveillance data, lab tests provided by a non-RWSP provider). RWSP evaluates these data sources to monitor adherence to the HIV/AIDS Bureau (HAB) performance measures and to identify areas in need of clinical quality improvement. RWSP's CQM program also relies on eHARS, RISE, and CAREWare to inform quality improvement goals and to identify priority populations. The Part B

recipient maintains no direct service sub-contracts. Its client-level data is collected using its proprietary ACAPS and CaseManager databases for medical services and case management services, respectively. Prevention data is collected and housed in the CDC-authorized, on-line EvaluationWeb data system.

Client-level utilization data entered into the respective data collection system is monitored at least monthly by the applicable recipient. In fact, RWSP data entered into CAREWare and RISE are monitored weekly by the CAREWare data manager and the business coordinators assigned to specific RWSP sub-recipients. Together with claims data, this information is used to adjust service category allocations and amend contracts as needed over the course of the fiscal period. For RWSP, re-allocations of greater than 5% from one service category to another require approval of the RWSP Planning Council; however, even lesser re-allocations are reviewed with the Planning Council for transparency and to elicit feedback regarding possible causes for the increased demand in one area compared to the decreased demand in another. Service utilization data are also used to inform priority service categories, for auditing purposes, to identify services that are under or over-utilized, and to identify populations and groups that are utilizing specific services at disproportionate rates. Utilization patterns are then used to inform quality improvement initiatives aimed at increasing utilization when necessary.

Measurement of Clinical Outcomes

As noted above, the RWSP and Part B recipients each prepare annual epidemiological profiles, Unmet Need reports, Community Viral Load Analysis summaries, and Clinical Quality Management (CQM) reports. In particular, the CQM reports and Viral Load Analyses are useful in identifying points along the HIV Care Continuum where efforts can be made to improve health outcomes of clients. The narrative below briefly describes the CQM Plans and Viral Load Analyses that are conducted by the RWSP and Part B recipients. Over the course of the five-year implementation period for this Integrated HIV Prevention and Care Plan, the RWSP and the Part B recipients intend to bring their respective processes into closer alignment in order to conserve resources and to improve comparability.

RWSP CQM Plan

The goal of the RWSP CQM program is to improve access to quality medical and supportive services for HIV-positive persons in the Indianapolis TGA. To achieve this goal, the program continuously monitors and evaluates quality and access to care. It participates in cross-disciplinary collaboration with epidemiologists, consumers, and HIV care providers to identify high-risk, high-priority patient populations; determine causal links between core and supportive services and client-level outcomes; determine service areas in need of improvement; and ensure that the RWSP provider network in the TGA functions in a seamless manner and improves the HIV continuum of care.

The CQM program monitors clinical performance measures on a quarterly basis to ensure that RWSP providers adhere to evidence-based practice guidelines and persons with HIV in the TGA receive high quality care. Since 2008, the Group 1 HAB performance measures have been used as a framework for monitoring quality of HIV care and for measuring client-level health outcomes. The program uses quantitative data obtained from service utilization, HIV surveillance databases, and electronic health records to evaluate clinical measures such as progression from HIV to AIDS; stage of HIV infection at initial diagnosis; maternal to child

transmission; retention in HIV care; and HIV mortality rate. Additional HAB measures have been incorporated since 2008, including several in 2012.

The RWSP CQM program works in collaboration with the RWSP Epidemiologist to obtain statistics on the number of clients who presented with AIDS at first diagnosis or who progressed to AIDS within 12 months of the initial diagnosis; the number of perinatally acquired HIV-infections; the percentage of clients retained in care at the end of the grant year; and the number of deaths within five years of an HIV/AIDS diagnosis. These data serve as a baseline measure for monitoring the long-range impact of the provision and utilization of comprehensive care on health outcomes. Expected short-term impacts include improved access to care as a result of supportive services such as transportation assistance; increased knowledge of HIV; increased utilization of support services; a reduced number of patients who are inactive or that have disengaged from care; and improved access to appropriate antiretroviral treatment.

The program compiles this information and issues an annual Clinical Quality Management Report which is presented to the RWSP Planning Council and serves as an additional source of information to be utilized in the process of planning, prioritizing, and implementing quality HIV services in the Indianapolis TGA. The program also maintains a formal CQM Plan which provides an infrastructure for ensuring quality of, and parity in, access to care. It outlines a strategy for addressing health outcomes along the Care Continuum for people living with HIV and for meeting the goals and objectives outlined in the National HIV/AIDS Strategy. The plan contains five major goals: 1) to increase early HIV disease detection; 2) to improve entry into and retention in care; 3) to improve access of recommended levels of care; 4) to assure the provision of quality core medical and supportive services; and, 5) to maintain a comprehensive CQM plan.

The CQM's client- and systems-level objectives address HAB measures and help to inform the HIV Care Continuum. Its objectives serve as indicators to measure progress towards improved health outcomes, reduction in health disparities, linkage to and retention in care, and other major goals outlined by national policy makers in directives such as the National HIV/AIDS Strategy, the National Monitoring Standards, and Healthy People 2020.

Additionally, the CQM plan includes performance measures that address all of the core and supportive services. To ensure consistency between the QM program goals and the "crosswalk" released by HAB, the services that most directly support improved health outcomes provide the framework for the RWSP's CQM program. To monitor progress towards implementing the five stages in the HIV Care Continuum, seven unique performance measures have been adopted. These measures expand across the 15 funded service categories. Performance outcomes provide quantifiable evidence that can be used to evaluate the quality of care in the TGA and identify improvement opportunities that will support achieving the goals outlined in the National HIV/AIDS Strategy.

RWSP Viral Load Analysis

In 2016, RWSP adopted a formal Viral Load Analysis Protocol in order to standardize and institutionalize the routine creation of a Viral Load Analysis Report that is in accordance with the National HIV/AIDS Strategy and the CDC guidance. The protocol calls for the RWSP to create a series of annual demographic "snapshot" reports comparing the viral suppression levels

of RWSP enrollees to non-enrollees using HIV surveillance and RWSP service utilization data. An example of information ascertained using this protocol is illustrated below (See [Table 19](#))

Table 19: Community Viral Load by RWSP Status

Community Viral Load by RWSP Status				
• Number and percent with suppressed viral load (<200 RNA copies/mL) at last CY 2015 test, by Ryan White HIV Services Program enrollment status				
RWSP Enrollment Status: CY 2015	N	% at <200 copies/mL	Geometric Mean Viral Load	95% Confidence Interval (GM)
Not Enrolled	1,481	81.4	76	66-87
Enrolled Part of the Year	1,291	84.4	61	53-69
Enrolled All Year[^]	1,238	87.6	48	42-54

[^] Experienced <30 day enrollment lapse during the year of interest

The protocol also includes the processes to be used to create an annual HIV Care Continuum graphic for the TGA using the data points noted earlier in the HIV Care Continuum description in Section I.

Part B CQM Plan

The Part B recipient is also committed to continual quality improvement and in accordance with the PHS Act, the mission of the Part B CQM Plan is to accurately assess the consistency of the HIV Medical Services Program – which includes the AIDS Drug Assistance Program (ADAP) – with the DHHS treatment guidelines and to ensure access to high quality health services for HIV-positive individuals in the state. Part B aims to accomplish this mission by gathering and reporting on relevant data elements and by implementing improvement activities based upon careful data analysis.

Demographic, health indication, and service utilization data are collected from the HIV Medical Services Program applications, re-certification interview records, claims data collected by the contracted insurers, and laboratory reports submitted to the Office of Clinical Data and research (OCDR). These data are reviewed at least quarterly to identify any areas of concern. Areas requiring attention are studied by the recipient and presented to the CHSPAC Evaluation Committee for its recommendations. Large-scale problems (i.e., barriers to physician access in rural areas) can be addressed in subsequent planning sessions where funding shifts can be considered. Small-scale problems (i.e., as suspected physician failure to adhere to DHHS treatment guidelines) are addressed immediately through provider education with the assistance of MATEC. Through this extensive data review, the recipient is able to closely monitor HIV-related illnesses and trends among the population being served and to document the extent to which those individuals receiving care through the program are experiencing positive health outcomes.

To specifically address its CQM Plan, the Part B recipient completes a series of four distinct activities annually: establishment of health indicators, database analysis, provider education, and supportive service intervention. The most recent data analysis focused on four legacy health indicators for quality care, as well as HAB's Group 1 performance measures. The legacy indicators included timeliness, compliance, appropriateness, and positive health outcomes. HAB's performance indicators included clinical measures of CD4 count, HAART, medical visits, PCP prophylaxis, and ARV therapy for pregnant women. Once the health indicators have been established, client-level service data is collated with surveillance information to determine the extent to which the measurement goals were achieved. Based on those results, the Part B recipient targets consumers and treating physicians with information, training, and other supports to reverse any negative outcomes. When necessary, the state's HIV Care Coordination Program is enlisted to intervene with specific clients and their health providers in any attempt to realize improved health outcomes.

The CHSPAC Evaluation Committee is integrally involved in the data analysis phase and in developing any intervention measures. Following the completion of the analysis phase, the Part B recipient issues the annual CQM report. Resulting interventions are reflected in the subsequent annual report.

Part B Viral Load Analysis

As an addendum to its regular Unmet Needs report, the Part B recipient prepared a baseline community viral load report in June of 2011, comparing the average viral load of enrollees to that of the general HIV-positive population in Indiana. At that time, the program was able to document that average HIV viral load for enrollees was 9,246 copies/mL, while that of the prevalence population was 41,139 copies/mL. The following year, the recipient expanded upon its original analysis by creating six tables to illustrate viral load for a number of relevant population groupings including:

- Indiana's Prevalence
- Indiana's Unmet Need Population
- Indiana's Medicaid Recipients
- HIV Medical Services Program Enrollees (who are required to be dually enrolled in HIV Care Coordination)
- HIV Care Coordination Program Enrollees (who may or may not have had HIAP¹ coverage)
- HIV Care Coordination Program Enrollees without HIAP (includes all insurance types except HIAP)

Results showed that program participants were 2-3 times more likely to receive viral load testing than Medicaid enrollees or the larger prevalence population, and 8-9 times more likely than the unmet need group. Additionally, average viral load among these groups indicated that those enrolled in both HIV Care Coordination and the HIV Medical Services Program achieved the greatest viral suppression while the Medicaid population and unmet need group were least likely to have suppressed viral loads. The analysis was repeated for 2012 and 2013; both years yielded similar results and led to adoption of the HIV Care Continuum model of evaluation. The most recent HIV Care Continuum information is included in Section I-B, illustrating that 59.6% of all

¹ HIAP is the Health Insurance Assistance Plan, a component of the HIV Medical Services Program operated by ISDH using Part B funds.

Indiana residents living with HIV had suppressed viral loads (<200 copies/mL) in calendar year 2015.

A component of each analysis though 2013 had been the creation of an HIV Treatment Cascade. Like the HIV Care Continuum, this graphic illustrated the population's movement along the continuum from diagnosis to viral suppression. In 2013, the Part B recipient attempted to enhance its cascade by using additional data points of interest. The relevant elements and the actual 2013 results are shown below. Moving forward, this cascade will be modified or enhanced to facilitate comparison to the HIV Care Continuum prepared annually by the RWSP and described in full in Section I.

This is a *living* document to be completed over the course of the calendar year. Each quarter, the progress to date as documented herein is to be shared with the Integrated Plan Contact Person. This document is to be maintained by the Monitoring Work Group co-chairs.

STRUCTURE	
Monitoring Work Group Composition – start	As of 1 January 2017 <ul style="list-style-type: none"> <input type="checkbox"/> The chair and two other members of CHSPAC; <input type="checkbox"/> The chair and two other members of CPG; <input type="checkbox"/> The chair and two other members of the Part A Planning Council; <input type="checkbox"/> A representative from MCPHD; and <input type="checkbox"/> A representative from ISDH.
Monitoring Work Group Meeting Frequency	2017 <ul style="list-style-type: none"> <input type="checkbox"/> Jan-Mar <input type="checkbox"/> Apr-Jun <input type="checkbox"/> Jul-Sep <input type="checkbox"/> Oct-Dec
Monitoring Work Group Composition – end	As of 31 December 2017 <ul style="list-style-type: none"> <input type="checkbox"/> The chair and two other members of CHSPAC; <input type="checkbox"/> The chair and two other members of CPG; <input type="checkbox"/> The chair and two other members of the Part A Planning Council; <input type="checkbox"/> A representative from MCPHD; and <input type="checkbox"/> A representative from ISDH.
Challenges	
Recommendations	
<input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>	

MILESTONES – Q1

<p>Initial Expectations</p>	<p>As of 1 January 2017</p> <ul style="list-style-type: none"> <input type="checkbox"/> Goals and objectives must be specific and measurable; <input type="checkbox"/> Basic evaluation tools must be finalized and available; <input type="checkbox"/> MCPHD and ISDH must have plans in place to ensure that future RFPs reflect the Integrated Plan; <input type="checkbox"/> MCPHD and ISDH must indicate that current funding is sufficient to achieve current goals; <input type="checkbox"/> MCPHD and ISDH must have plans to seek additional funds to expand and improve services in subsequent years; <input type="checkbox"/> ISDH must have a plan to assess and update its current funding methodology for prevention services; <input type="checkbox"/> MCPHD and ISDH must have plans in place (and preferably documented in future RFPs) to improve the performance of under-achieving programs; <input type="checkbox"/> MCPHD and ISDH must have plans to adopt minimum score thresholds for RFP responses to help ensure the quality and capacity of providers. <input type="checkbox"/> MCPHD and ISDH must have plans in place to expand the capacity of overwhelmed programs in areas of high-need (e.g., such programs may be encouraged or required to utilize a funding matrix similar to the one used for the Housing Continuum of Care to identify and seek other potential funding sources for programming).
<p>Reaction To Emergent Issues</p>	<p>January – March 2017</p>
<p>Challenges</p>	
<p>Recommendations</p> <p><input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i></p>	

MILESTONES – Q2

Completed Projects	As of 30 June 2017 <ul style="list-style-type: none"> <input type="checkbox"/> Revised state epidemiological data; <input type="checkbox"/> Revised TGA epidemiological data; <input type="checkbox"/> Part A Viral Load Analysis report; <input type="checkbox"/> Unmet Need report for Part A; and <input type="checkbox"/> Unmet Need report for Part B (including Viral Load Analysis).
Reaction To Emergent Issues	April – June 2017
Challenges	
Recommendations <p><input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i></p>	

MILESTONES – Q3

Completed Projects	As of 30 September 2017 <ul style="list-style-type: none"> <input type="checkbox"/> Quality Management report for Part A; <input type="checkbox"/> Quality Management report for Part B; <input type="checkbox"/> SPSP Testing Site Visit report summary; <input type="checkbox"/> ISDH Prevention Site Visit report summary; and <input type="checkbox"/> Part A site visit report summary.
Reaction To Emergent Issues	April – June 2017
Challenges	
Recommendations	
<input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>	

MILESTONES – Q4

Completed Projects	As of 31 December 2017 <input type="checkbox"/> Objectives Progress Report – <i>see next section</i>
Reaction To Emergent Issues	April – June 2017
Summary of Challenges	
Summary of Recommendations <input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>	

GOAL 1 – Reducing new HIV infections					
Objective 1 <i>Increase the percentage of people living with HIV who know their serostatus to at least 90% by 2021</i>	ANNUAL TARGETS ²				
	2017	2018	2019	2020	2021
	87.7%	88.2%	88.8%	89.4%	90.0%
	As of 31 December 2017				
	Numerator. Number of persons in Indiana aged ≥ 13 years at diagnosis with diagnosed HIV infection at the end of the calendar year.				
	Denominator. Number of persons in Indiana aged ≥ 13 years at diagnosis living with HIV infection (diagnosed and undiagnosed ³) at the end of the calendar year.				
<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result		
Objective 2 <i>Reduce the number of new diagnoses by at least 25%⁴ by 2021</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	494	468	442	416	390
	As of 31 December 2017				
	Numerator. Number of (unadjusted) HIV diagnoses among persons of all ages in Indiana during the calendar year and reported to OCDR within 18 months of the diagnosis year.				
	Denominator. Not applicable.				
<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	--	
Challenges					
Recommendations					
<input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>					

² These are the national targets shifted forward one year. The national targets use a 2010 baseline with a 90% goal by 2020 (instead of 2021). The national targets can be found at: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf. Updated targets can be found at: https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf.

³ Based on the estimate provided by the Centers of Disease Control and Prevention for the applicable period. See <http://www.cdc.gov/hiv/statistics/overview/ataglance.html> for example.

⁴ Compared to the number of new diagnoses in 2011 (which was 500 cases according to [http://www.in.gov/isdh/files/2012_Epi_Profile_Executive_Summary\(1\).pdf](http://www.in.gov/isdh/files/2012_Epi_Profile_Executive_Summary(1).pdf)).

GOAL 2 – Increasing access to care and improving health outcomes for people living with HIV

Objective 1 <i>Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85% by 2021</i>	ANNUAL TARGETS⁵				
	2017	2018	2019	2020	2021
	76.9%	78.3%	80.6%	82.8%	85.0%
	As of 31 December 2017				
	Numerator. Number of persons in Indiana aged ≥ 13 years newly diagnosed during the calendar year who were linked to care within one month of their diagnosis date as measured by a documented test result for a CD4 or viral load.				
	Denominator. Number of persons aged ≥ 13 years diagnosed with HIV infection during the calendar year in Indiana.				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Objective 2 <i>Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90% by 2021</i>	ANNUAL TARGETS⁶				
	2017	2018	2019	2020	2021
	58%	66%	74%	82%	90.0%
	As of 31 December 2017				
	Numerator. Number of persons in Indiana aged ≥ 13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 or viral load.				
	Denominator. Number of persons in Indiana aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Objective 3 <i>Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80% by 2021</i>	ANNUAL TARGETS⁷				
	2017	2018	2019	2020	2021
	63.7%	67.8%	71.9%	76.0%	80.0%
	As of 31 December 2017				
	Numerator. Number of persons in Indiana aged ≥ 13 years with diagnosed HIV infection whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. ⁸				
	Denominator. Number of persons in Indiana aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Challenges					
Recommendations					
<input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>					

⁵ These are the national targets shifted forward one year. The national targets use a 2010 baseline with an 85% goal by 2020 (instead of 2021). The national targets can be found at: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf. Updated targets can be found at: https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf.

⁶ These are the national targets shifted forward one year. The national targets use a 2010 baseline with a 90% goal by 2020 (instead of 2021).

⁷ These are the national targets shifted forward one year. The national targets use a 2010 baseline with a 80% goal by 2020 (instead of 2021). The national targets can be found at: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf. Updated targets can be found at: https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf.

⁸ Defined as "<200 copies/mL."

GOAL 3 – Reducing HIV-related disparities and health inequities

Objective 1A <i>Reduce disparities in the rate of new diagnoses by at least 15%⁹ among men who have sex with men (MSM) by 2021</i>	ANNUAL TARGETS¹⁰				
	2017	2018	2019	2020	2021
	15	14.9%	14.5	14.0	13.5
	As of 31 December 2017				
	Numerator. The diagnosis disparity rate for MSM, calculated by subtracting the diagnosis rate ¹¹ for the overall population in Indiana from the diagnosis rate for only MSM.				
	Denominator. The rate of HIV diagnosis for the overall population (all persons) in Indiana in the calendar year. ¹²				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Objective 1B <i>Reduce disparities in the rate of new diagnoses by at least 15%¹³ among African Americans by 2021</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	2.36	2.29	2.21	2.14	2.07
	As of 31 December 2017				
	Numerator. The diagnosis disparity rate for African Americans, calculated by subtracting the diagnosis rate ¹⁴ for the overall population in Indiana from the diagnosis rate for only African Americans.				
	Denominator. The rate of HIV diagnosis for the overall population (all persons) in Indiana in the calendar year. ¹⁵				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Objective 1C <i>Reduce disparities in the rate of new diagnoses by at least 15%¹⁶ among people who inject drugs by 2021</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	19.7	19.1	18.5	17.9	17.3
	As of 31 December 2017				
	Numerator. The diagnosis disparity rate for people who inject drugs, calculated by subtracting the diagnosis rate ¹⁷ for the overall population in Indiana from the diagnosis rate for only people who inject drugs.				
	Denominator. The rate of HIV diagnosis for the overall population (all persons) in Indiana in the calendar year. ¹⁸				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	

⁹ Compared to national disparity rate in 2011 which was 20.3%. See

https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf.

¹⁰ These are the national targets shifted forward one year. The national targets use a 2010 baseline with a 17.4% goal by 2020 (instead of 2021). The national targets can be found at: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf. Updated targets can be found at:

https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf

¹¹ The diagnosis rate is calculated from the number of (unadjusted) HIV diagnoses during the calendar year and reported to OCDR within 18 months of the diagnoses year.

¹² The rate is per 100,000 population.

¹³ Compared to the Indiana disparity rate in 2011 which was 37.7%

¹⁴ The diagnosis rate is calculated from the number of (unadjusted) HIV diagnoses during the calendar year and reported to OCDR within 18 months of the diagnoses year.

¹⁵ The rate is per 100,000 population.

¹⁶ Compared to the Indiana disparity rate in 2011 which was 0.2%

¹⁷ The diagnosis rate is calculated from the number of (unadjusted) HIV diagnoses during the calendar year and reported to OCDR within 18 months of the diagnoses year.

¹⁸ The rate is per 100,000 population.

GOAL 3 cont'd

Objective ID	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
Objective 1D <i>Reduce disparities in the rate of new diagnoses by at least 15%¹⁹ among young adults (age 20-29) by 2021</i>	1.74	1.68	1.62	1.56	1.50
	As of 31 December 2017				
	Numerator. The diagnosis disparity rate for young adults, calculated by subtracting the diagnosis rate ²⁰ for the overall population in Indiana from the diagnosis rate for only young adults.				
	Denominator. The rate of HIV diagnosis for the overall population (all persons) in Indiana in the calendar year. ²¹				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Objective 2A <i>Increase viral suppression to at least 80% among African Americans by 2021²²</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	50.4%	57.8%	85.2%	72.6%	80.0%
	As of 31 December 2017				
	Numerator. Number of HIV-diagnosed African Americans in Indiana whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. ²³				
Denominator. Number of persons in Indiana aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.					
<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result		
Objective 2B <i>Increase viral suppression to at least 80% among young adults (age 20-29) by 2021²⁴</i>	ANNUAL TARGETS ²⁵				
	2017	2018	2019	2020	2021
	45.4%	54.1%	62.7%	71.4%	80.0%
	As of 31 December 2017				
	Numerator. Number of HIV-diagnosed young adults in Indiana whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed. ²⁶				
Denominator. Number of persons in Indiana aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.					
<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result		

¹⁹ Compared to the Indiana disparity rate in 2011 which was 21.5%

²⁰ The diagnosis rate is calculated from the number of (unadjusted) HIV diagnoses during the calendar year and reported to OCDR within 18 months of the diagnoses year.

²¹ The rate is per 100,000 population.

²² Compared to the 2011 baseline of 40.3% (using the Indianapolis TGA as a proxy for unavailable statewide data).

²³ Defined as "<200 copies/mL."

²⁴ This objective is similar to the national indicator but uses a slightly different age range. Here, "young adults" are aged 20-29. "Youth" for the national indicator would be defined as ≥ 13 years but ≤ 24 years. See <http://www.cdc.gov/hiv/group/age/youth/index.html>. Regardless, the national targets are used here.

²⁵ These are the national targets shifted forward one year. The national targets use a 2010 baseline with a 80% goal by 2020 (instead of 2021).

The national targets can be found at: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf.

Updated targets can be found at:

https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf

²⁶ Defined as "<200 copies/mL."

GOAL 3 cont'd

Objective 2C <i>Increase viral suppression to at least 80% among people who inject drugs by 2021</i>	ANNUAL TARGETS ²⁷				
	2017	2018	2019	2020	2021
	TBA	TBA	TBA	TBA	TBA
As of 31 December 2017					
Numerator. Number of HIV-diagnosed Indiana residents who have a history of injecting drugs and whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed (<200 coies/mL). ²⁸					
Denominator. Number of Indiana residents who have a history of injection drugs with HIV infection diagnosed by previous year-end and alive at year-end.					
<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result		
Challenges					
Recommendations					
<input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>					

²⁷ These are the national targets shifted forward one year. The national targets use a 2010 baseline with a 80% goal by 2020 (instead of 2021). The national targets can be found at: https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf. Updated targets can be found at: https://www.whitehouse.gov/sites/whitehouse.gov/files/documents/NHAS_Indicator_Supplement_July_2016.pdf

²⁸ Defined as "<200 copies/mL."

GOAL 4 – Achieving a more coordinated response to the HIV epidemic

Objective 1 <i>Increase the coordination and integration of HIV prevention and care services across programs and agencies through 2021</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	90%	95%	100%	105%	110%
	As of 31 December 2017				
	Numerator. Number of agencies receiving both service and prevention funding from either the State or Marion Counties in the current year.				
	Denominator. Number of agencies receiving both service and prevention funding from either the State or Marion County in the prior year.				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Objective 2 <i>Maintain a comprehensive integrated statewide plan for HIV prevention and care by updating the plan on an annual basis through 2021</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	1	1	1	1	1
	As of 31 December 2017				
	Numerator. Number of plans that were originally issued or updated and released during the first quarter of the calendar year.				
	Denominator. Not applicable.				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Challenges					
Recommendations					
<input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>					

GOAL 5 – Ensuring continued financial and other resources to support HIV service delivery

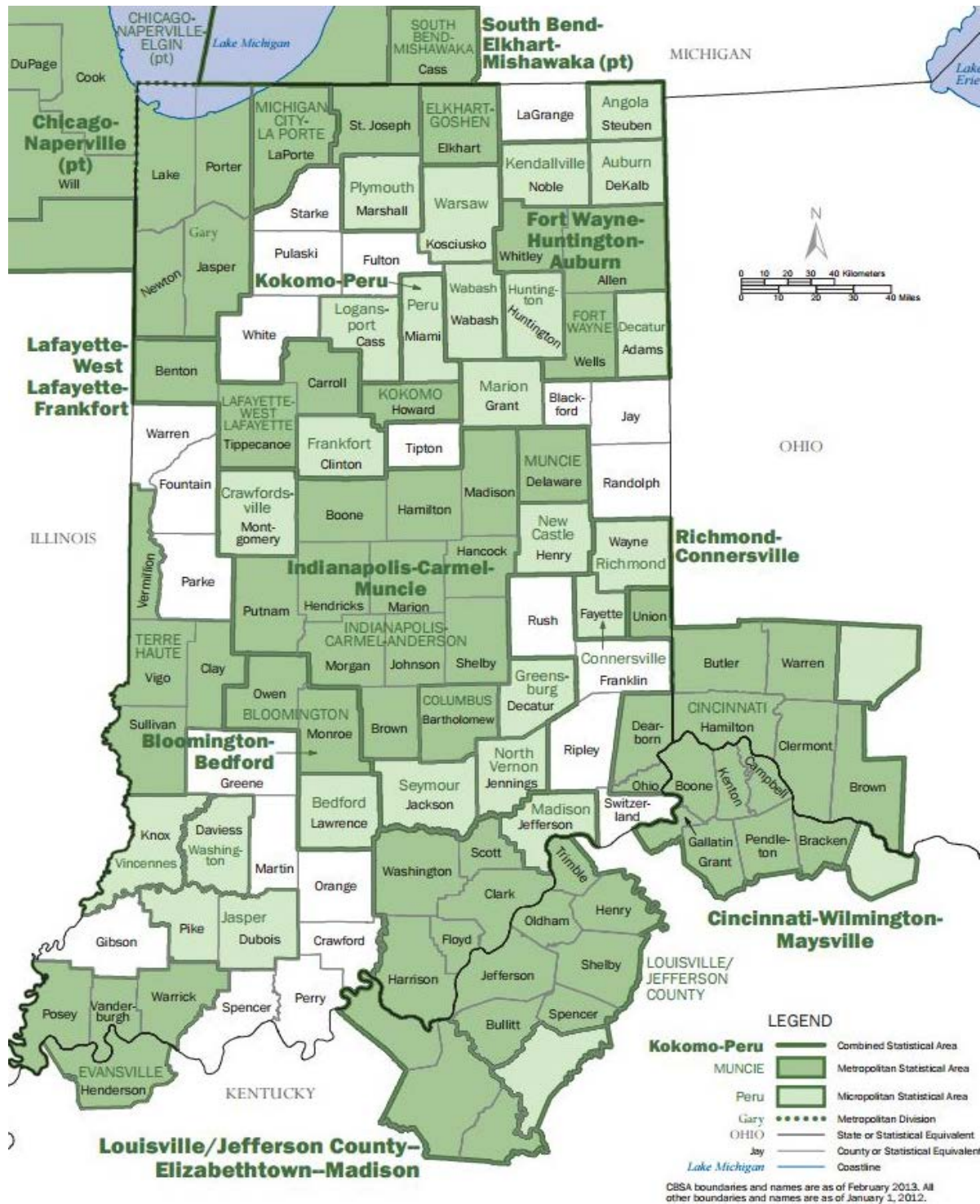
Objective 1 <i>Maintain stable and diverse funding streams to support HIV prevention and care service delivery through 2021</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	100%	100%	100%	100%	100%
	As of 31 December 2017				
	Numerator. This year’s combined state and Marion counties budgets for HIV services and prevention efforts.				
	Denominator. Previous year’s combined State and Marion County budgets for HIV services and prevention efforts.				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Objective 2 <i>Increase the fiscal health and stability of agencies providing HIV prevention and care services through 2021</i>	ANNUAL TARGETS				
	2017	2018	2019	2020	2021
	100%	100%	100%	100%	100%
	As of 31 December 2017				
	Numerator. Total number of agencies funded by the State and Marion County to deliver HIV services and prevention at the beginning of the calendar year that are still in operation at the end of the calendar year.				
	Denominator. Total number of agencies funded by the State and Marion County to deliver HIV services and prevention at the beginning of the calendar year.				
	<input type="checkbox"/> NOT ACHIEVED	<input type="checkbox"/> ACHIEVED	<input type="checkbox"/> EXCEEDED	Result	
Challenges					
Recommendations					
<input type="checkbox"/> <i>Recommendations may require edits to future editions of the Integrated Plan</i>					

ADDITIONAL COMMENTS

It is the intent of the Monitoring Work Group that this completed tracking tool be used to enhance and improve the next edition of the Integrated HIV Prevention and Care Plan which is due to be completed by 31 March 2018.

Appendix 1

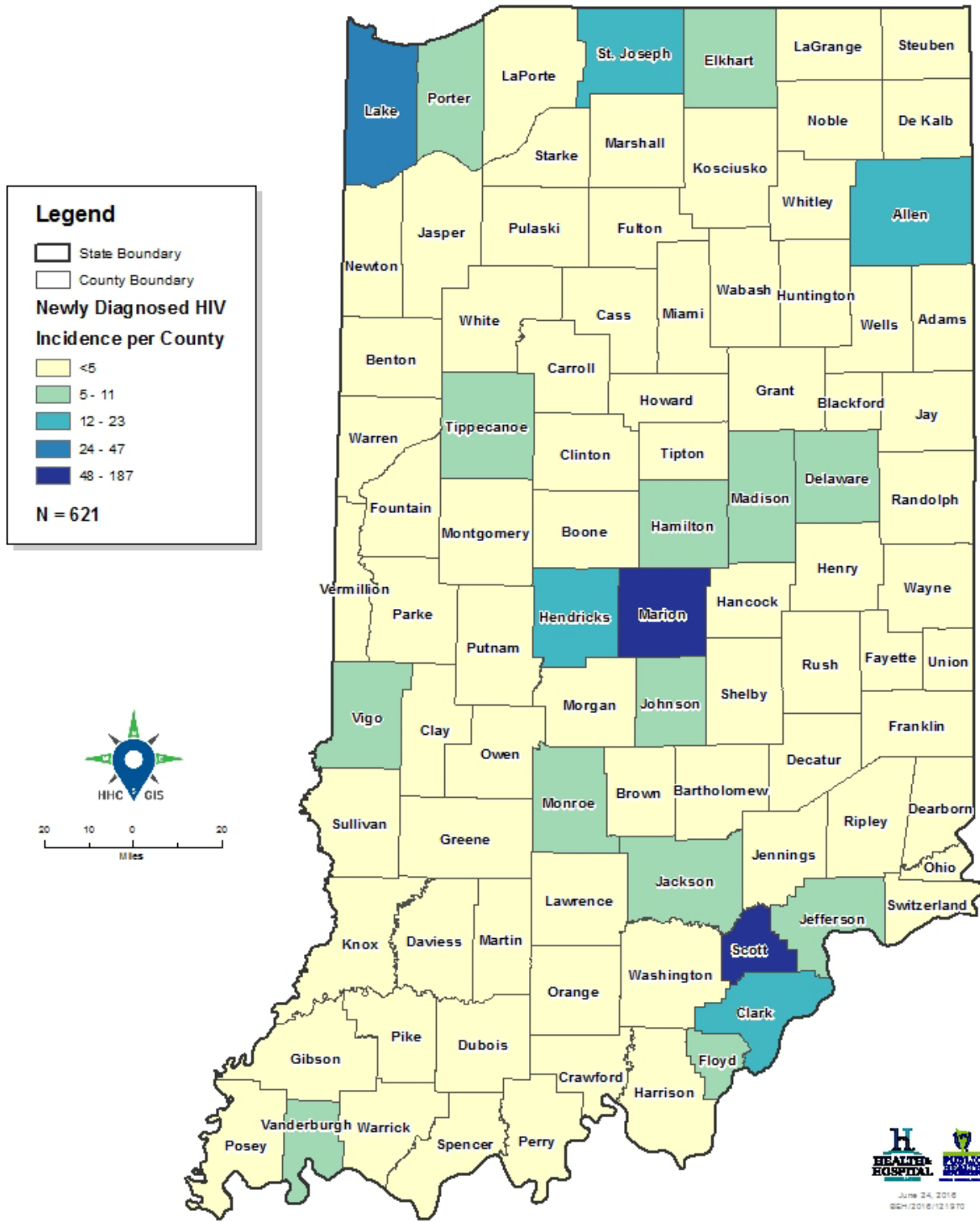
Indiana's Core Based and Metropolitan Statistical Areas and Counties



Source: U.S. Department of Commerce Economics and Statistics Administration, U.S. Census Bureau

Appendix 2

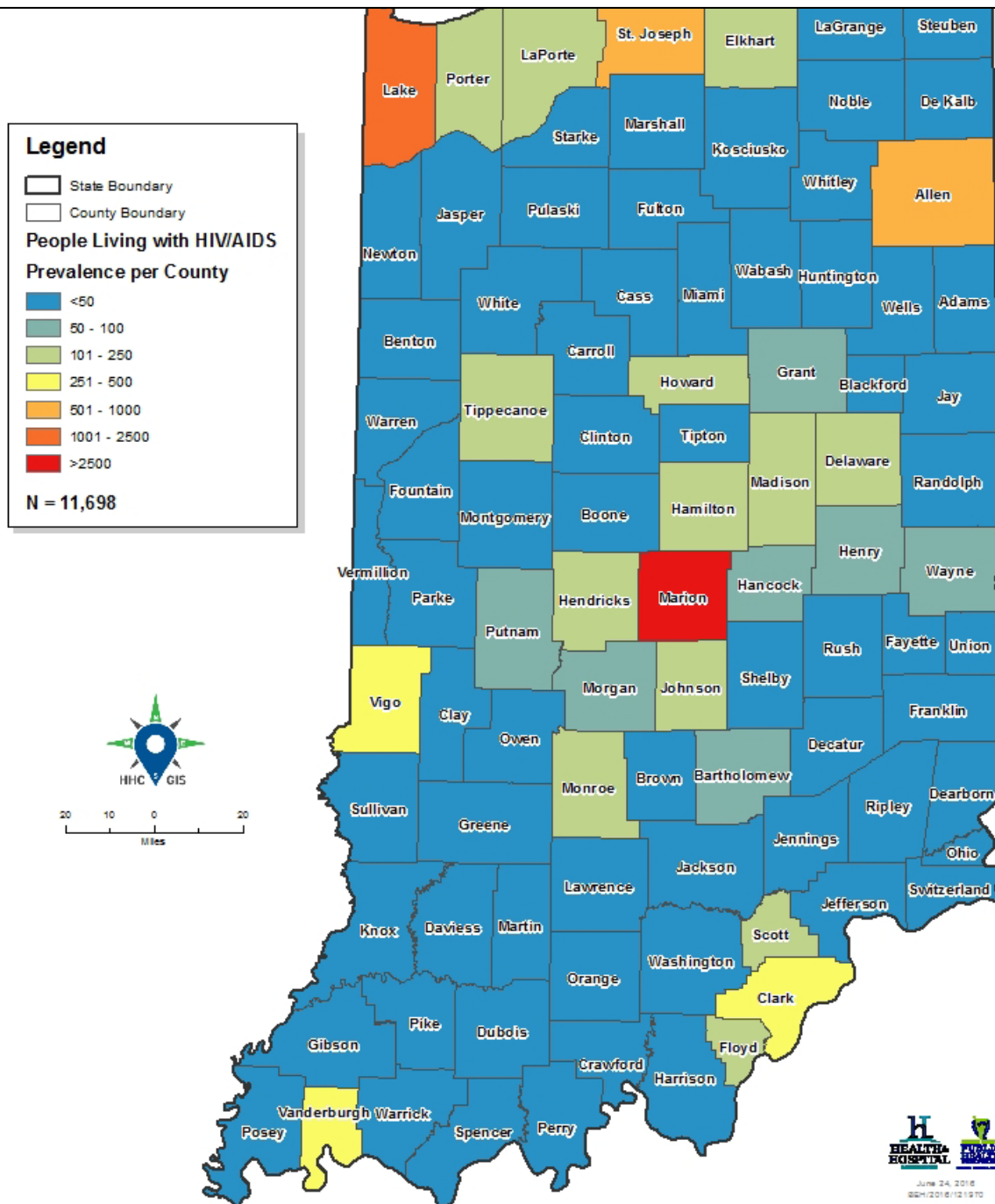
Newly Diagnosed HIV (N) among Indiana Residents, by County: CY 2015



Created 24 JUN 2016, Marion County Public Health Department, Epidemiology DR2764, GIS 121970. Source: eHARS/ISDH.

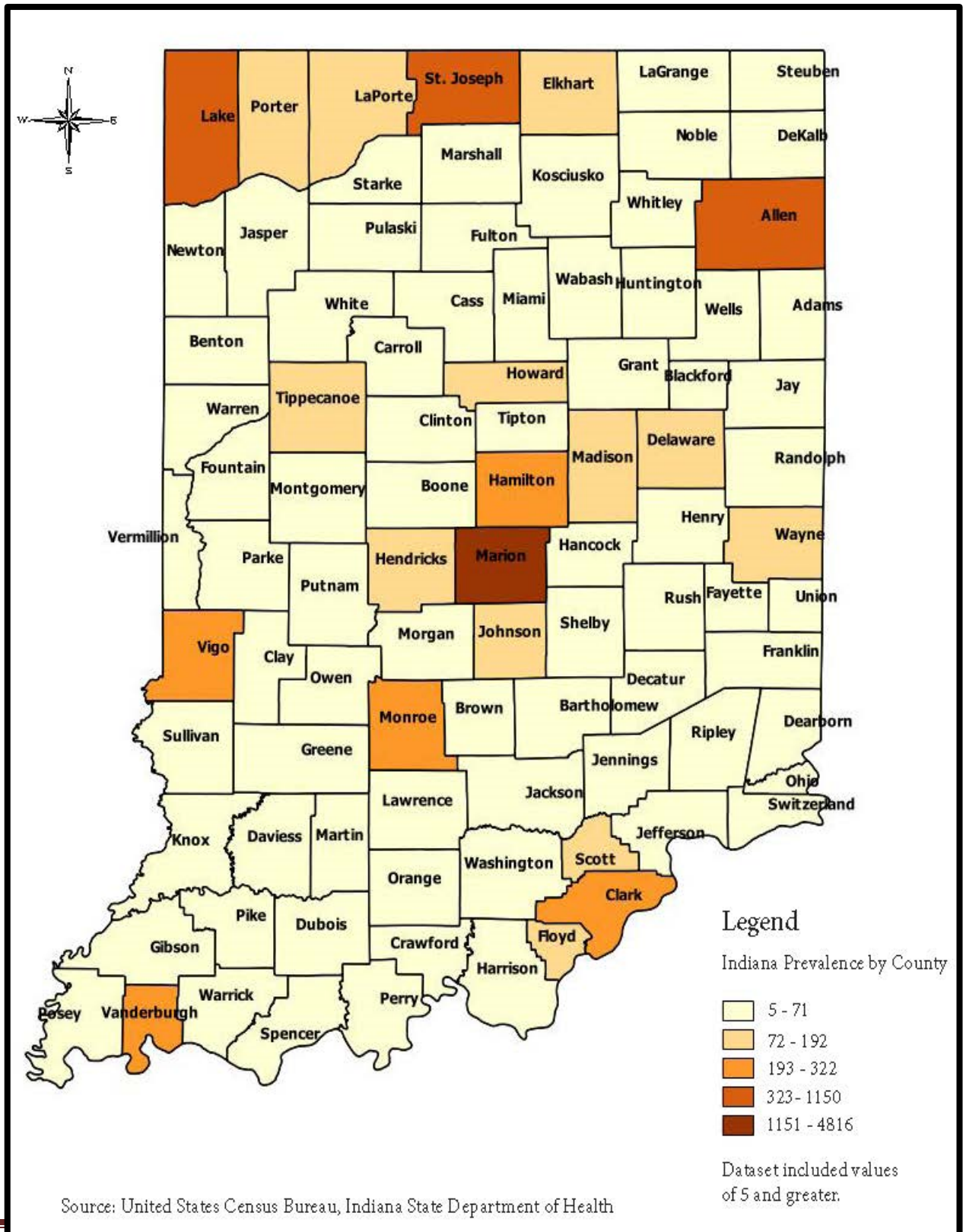
Appendix 3

Indiana Residents Living with HIV/AIDS (N), by County: CY 2015

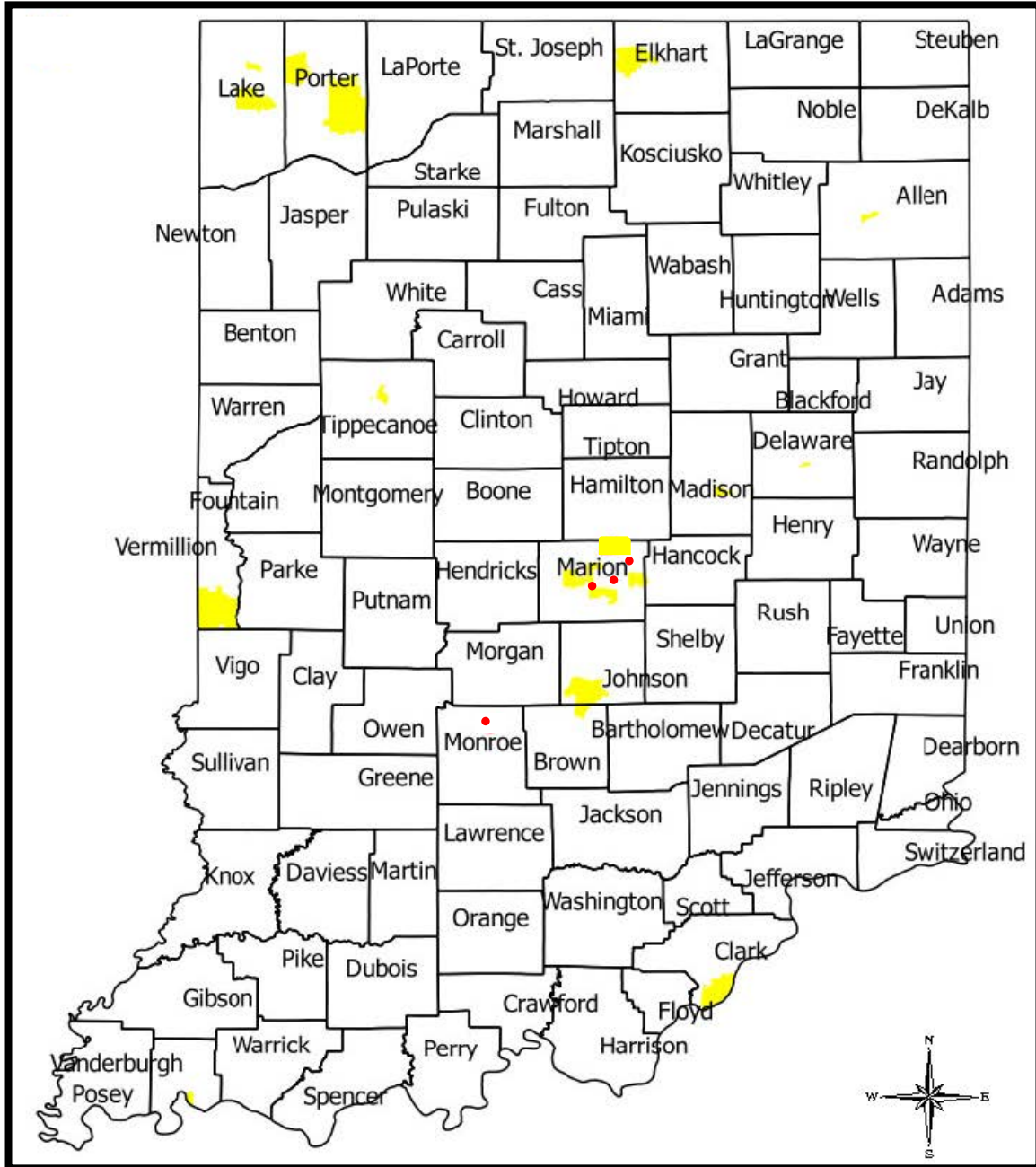


Created 24 JUN 2016, Marion County Public Health Department, Epidemiology DR2764, GIS 121970. Source: eHARS/ISDH.

Appendix 4: 2015 HIV Prevalence by County



Appendix 5: Community Health Centers currently providing HIV Clinical Care and Ryan White Clinical Sites*

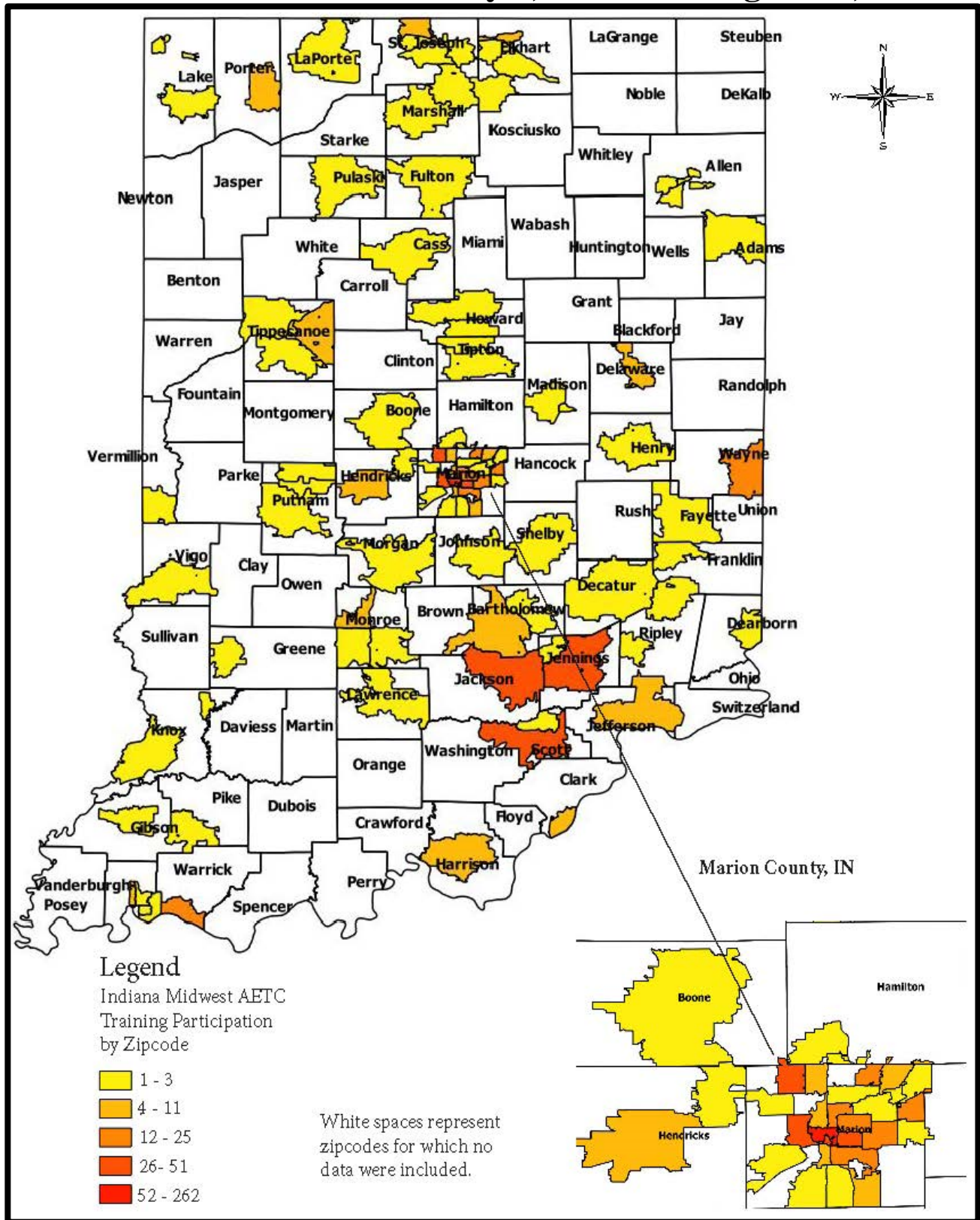


Source: United States Census Bureau. Data Warehouse, HRSA

*Represents location of funded entity may not represent where patients are seen.

- Community Health Centers
- Ryan White Centers
- Both

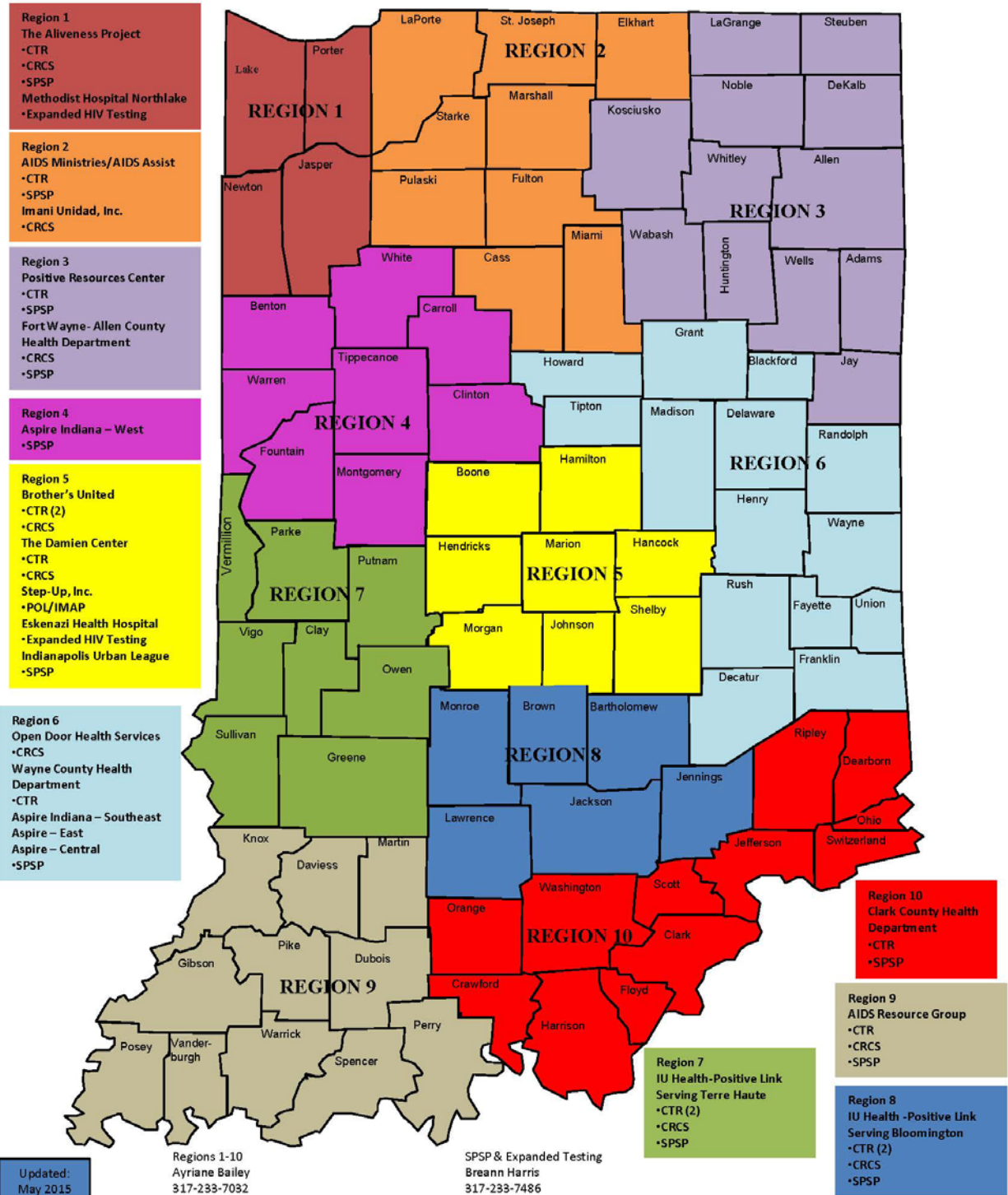
Appendix 6: MATEC Trainees between July 1, 2014 and August 31, 2015



Appendix 7

Counseling, Testing and Referral Statewide Map

HIV PREVENTION REGIONAL MAP



References

-
- ¹ U.S. Census Bureau. (2016). Core based statistical areas (CBSAs), metropolitan divisions, and combined statistical areas (CSAs), July 2015. Retrieved from http://www2.census.gov/geo/maps/metroarea/stcbsa_pg/Feb2013/cbsa2013_IN.pdf
- ² U.S. Census Bureau. (2015). Annual estimates of the resident population for the United States, regions, states, and Puerto Rico: April 1, 2010 to July 1, 2015. Release date: December 2015. Retrieved from <http://www.census.gov/popest/data/national/totals/2015/files/NST-EST2015-alldata.csv>
- ³ Centers for Disease Control and Prevention. (2015). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data - United States and 6 dependent areas - 2013. *HIV Surveillance Supplemental Report*, 20(2). Retrieved from http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report_vol20_no2.pdf
- ⁴ U.S. Census Bureau. (2016). Core based statistical areas (CBSAs), metropolitan divisions, and combined statistical areas (CSAs), July 2015. Retrieved from http://www2.census.gov/geo/maps/metroarea/stcbsa_pg/Feb2013/cbsa2013_IN.pdf
- ⁵ U.S. Census Bureau. (2015). Annual estimates of the resident population for the United States, regions, states, and Puerto Rico: April 1, 2010 to July 1, 2015. Release date: December 2015. Retrieved from <http://www.census.gov/popest/data/national/totals/2015/files/NST-EST2015-alldata.csv>
- ⁶ Centers for Disease Control and Prevention. (2015). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data - United States and 6 dependent areas - 2013. *HIV Surveillance Supplemental Report*, 20(2). Retrieved from http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report_vol20_no2.pdf
- ⁷ Norris, L. (2015). Indiana health insurance exchange/marketplace. Retrieved from <https://www.healthinsurance.org/indiana-state-health-insurance-exchange/>
- ⁸ U.S. Department of Health and Human Services. (2014). 2014 poverty guidelines. Retrieved from <https://aspe.hhs.gov/2014-poverty-guidelines>
- ⁹ Henry J. Kaiser Family Foundation. (2015). Key facts about the uninsured population. Retrieved from <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>
- ¹⁰ Centers for Disease Control and Prevention. (2015). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data - United States and 6 dependent areas - 2013. *HIV Surveillance Supplemental Report*, 20(2). Retrieved from http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report_vol20_no2.pdf
- ¹¹ Centers for Disease Control and Prevention. (2015). HIV among transgender people. Retrieved from <http://www.cdc.gov/hiv/group/gender/transgender/>
- ¹² Centers for Disease Control and Prevention. (2015). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data - United States and 6 dependent areas - 2013. *HIV Surveillance Supplemental Report*, 20(2). Retrieved from http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report_vol20_no2.pdf
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